THE DELPHI CORPORATION

SALARIED HEALTH CARE PROGRAM

This edition contains all Program amendments made effective between January 1, 2006 and January 1, 2009

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ARTICLE I

ESTABLISHMENT, FINANCING AND ADMINISTRATION OF THE SALARIED HEALTH CARE PROGRAM

Section 1. Establishment and Effective Date of the Program

(a) Establishment of the Program

Delphi Corporation, on behalf of itself and its constituent group and as agent for certain of its directly or indirectly wholly-owned and substantially wholly-owned domestic subsidiaries, will establish a Salaried Health Care Program, hereinafter referred to as the Program or this Program, either through a self-insured plan or by other arrangement.

(b) Reservation of Rights

(1) The Corporation reserves the right to amend, modify, suspend or terminate the Program in whole or in part, at any time, by action of its Board of Directors or other committee expressly authorized by the Board to take such action. No enrollee described in this Program may be deemed to have any vested right to continued coverage under any or all of the provisions of the Program.

(2) No oral or written statements can change the terms of this Program. This Program can only be amended by an appropriate committee as designated by the Board of Directors. Absent an express delegation of authority from the Board of Directors, no one has the authority to commit the Corporation to any benefit or benefit provision not provided for under the Program or to change the eligibility criteria or other provisions of the Program.

(3) In the event the initiation of any benefit(s) or coverage(s) described in the Program does not prove practicable or if the carriers are unable to provide such benefit(s) or coverage(s) on the dates stipulated in such Program, the

Corporation may provide new, different or no benefit(s) and/or coverage(s).

(c) Effective Date

This Program is effective January 1, 2007. Until January 1, 2007, the provisions of the prior Program were in effect unless expressly indicated otherwise. This Program shall continue in effect until amended, modified, suspended or terminated by the Corporation as specified above.

Section 2. Corporation Costs and Administrative Items

(a) Net Costs

(1) The Corporation, or a trust, shall pay the balance of the net cost of the Program over and above any enrollee contributions or payments specified under the Program. The Corporation, or a trust, shall receive and retain any credits, refunds, or reimbursements under whatever name, arising out of the Program.

(2) The Corporation, by payment of its contributions (whether by paying claims through carriers administering the Program or by any other manner) shall be relieved of any further liability with respect to the coverage(s) or benefit(s) provided under the Program, except as otherwise may be required by the Employee Retirement Income Security Act of 1974, as amended.

(3) Certain enrollees may be offered choices among various health care options. The performance of options may be evaluated by the Corporation. Contributions by enrollees may be required to participate in the Program, or in an option, and may be based on the status of the primary enrollee, the number of covered enrollees, the Medicare status of enrollees and the relative performance of the options available or elected. To the extent permitted by law, such required enrollee contributions shall be by payroll or other similar deduction.

(4) Subject to the Corporation's reserved right to amend, modify or terminate the Program, the Corporation will share future Program cost increases with enrollees, on an aggregate basis

to be determined by the Corporation. Such enrollee cost sharing may be in the form of monthly contributions, deductibles, copayments, other design changes or any combination of the preceding.

(b) Administration

(1) Delphi Corporation is the Plan Administrator. The Plan Administrator has discretionary authority to construe, interpret, apply and administer the Program. The Plan Administrator may delegate various aspects of Program administration as it deems appropriate.

(2) Various aspects of Program administration have been delegated to carriers. In carrying out their delegated responsibilities, the carriers shall have discretionary authority to construe, interpret, apply and administer the Program provisions. The discretionary authority delegated to a carrier shall, however, be limited to Program terms relevant to its delegated responsibilities, and shall not permit a carrier to render a determination or make any representation concerning benefits which are not provided by the express terms of the Program. The carriers' actions shall be given full force and effect unless determined by the Plan Administrator to be contrary to the Program provisions or arbitrary and capricious.

(3) The Employee Benefit Plans Committee (EBPC) of the Corporation has final discretionary authority to construe, interpret, apply and administer the Program, which includes making factual determinations and serves as the final step of the Program appeal procedure. Any interpretation or determination regarding the Program made by the EBPC shall be given full force and effect, unless it is proven that the interpretation or determination was arbitrary and capricious.

(c) Grievance Procedure Not Applicable

It is understood that the grievance procedure of any collective bargaining agreement between the Corporation and any union representing salaried employees of the Corporation shall not apply to this Program or any contract in connection therewith.

(d) Miscellaneous Information Related to the Employee Retirement Income Security Act of 1974 (ERISA)

(1) The end of the plan year is December 31. Records of the Program are kept on a calendar year basis.

(2) Delphi Corporation is the sponsoring employer and Administrator of the Program. The Administrator's address is Mail Code 480-410-104, 5825 Delphi Drive, Troy, Michigan 48098.

(3) Service of legal process on Delphi Corporation may be made at any office of the CT Corporation. The CT Corporation, which maintains offices in all 50 states, is the statutory agent for service of legal process on Delphi Corporation. The procedure for making such service generally is known to practicing attorneys. Service of legal process also may be made upon Delphi Corporation, at the Service of Process Office, Mail Code 480-410-254, 5825 Delphi Drive, Troy, Michigan, 48098.

(e) Time Limit for Claim Submission

Claims should be filed with the appropriate carrier as services are rendered and expenses are incurred. However, claims must be submitted not later than the end of the calendar year following the year in which services are rendered.

(f) Assignment or Alienation of An Enrollee's Interests

Except as expressly authorized by this Program or as required to comply with the legally applicable provisions of a Qualified Medical Child Support Order under the Omnibus Budget Reconciliation Act of 1993, benefits, claims, coverage or other interests in the Program may not be assigned, transferred or alienated by an enrollee. With the approval of the Corporation however, a carrier may pay a provider directly for services rendered, in lieu of payment to an enrollee.

Section 3. Program in States With Health Insurance Laws

(a) To the extent the Corporation and the Program are not required, under Federal law, to comply with state-legislated mandates concerning health insurance coverages, the provisions of this Program need not be modified in states having laws which now or hereafter

may provide health care coverages, under whatever name, for enrollees who are disabled by non-occupational sickness or accident, or similar disability. If, under Federal law, the Corporation and the Program are subject to state-legislated mandates, compliance with such laws shall be deemed full compliance with the provisions of the Program with respect to enrollees in such states. If coverage under such state-legislated mandates exceeds the coverage provided under the Program, the Corporation may require such contributions as it may deem appropriate from enrollees in such states. If appropriate coverage under such state-legislated mandates is generally lower in level than the corresponding coverage under the Program, the Corporation may, at its sole discretion and to the extent it elects to do so, provide coverage supplementary to the state plan.

(b) Not withstanding the provisions of subsection (a) above, in any state which has a state-legislated plan of health coverage available to the general population including Program enrollees (or which would be available to Program enrollees but for their coverage under the Program), the Corporation may, at its sole discretion and to the extent permitted by the applicable state legislation, amend, modify, suspend, cancel or otherwise affect the provisions of the Program as they apply to enrollees in such states, in order to permit participation in such state plan in lieu of coverage under the Program.

Section 4. Federal Health Care Coverage

(a) Not Applicable to Enrollees Eligible for Such Coverage

The provisions of the Program, separately or in combination, shall not be applicable to enrollees eligible for health care coverage under any Federal health security act or any other Federal law providing such may be amended or enacted. Compliance by the Corporation with such laws shall be deemed full compliance with the provisions of the Program with respect to enrollees eligible for coverage under such laws. If such coverage exceeds the coverage provided under the Program and the Corporation's contributions for such coverage under the Program, the Corporation may require from such enrollees such contributions as it may deem appropriate for such excess coverage. If, as a result of such laws, the level of coverage provided for any group of enrollees is generally lower

than the corresponding level of coverage under the Program, the Corporation may, at its option and to the extent it finds it practicable, provide a plan of coverage supplementary to the Federal coverage to the extent necessary to make total coverage as nearly comparable as practicable to the coverage provided under the Program.

(b) Substitution of Applicable Provisions of the Program for Coverage Under Federal Laws

Notwithstanding the provisions of subsection (a) above, the Corporation may, if Federal laws permit, substitute a plan of coverage for the coverage provided by the Federal laws referred to in subsection (a) above, and modify the provisions of the Program to the extent and in the respects necessary to secure the approval of such substitution from the appropriate governmental authority and may make such plan available to enrollees.

(c) Reduction of Health Care Coverage Because of Coverage Under Federal Law

Health care benefits, separately or in combination, provided enrollees under the Program may be reduced by the amount of such coverage provided under any Federal health security act or any other Federal law which may be amended or enacted. In cases where the enrollee exercises an option under the Federal Social Security Act or similar law to take cash payments in lieu of health care coverages, the equivalent of such payments will be required as a contribution toward the health care coverages provided under the Program, but not to exceed the cost to the Corporation of such coverages. Such contributions may be deducted, in accordance with any applicable Federal laws, from any monies then payable to the enrollee in the form of salary or benefits payable under any Delphi benefit plan or program.

Section 5. Treatment of Existing Coverages on Effective Date

Protection of enrollees covered under the prior Delphi Salaried Health Care Program shall be terminated on the effective dates of the provisions of this Program, and the provisions of this Program shall be in lieu of and substitute for any and all other provisions of any such prior Program providing for health care benefits of any kind or nature, in which the salaried employees of the Corporation participated

Section 6. Named Fiduciary and Appeal Procedure

(a) The Executive Committee of the Corporation's Board of Directors shall be the Named Fiduciary with respect to the Program. The Executive Committee may delegate authority to carry out such of its responsibilities as it deems proper to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended.

(b) A mandatory appeal procedure has been established for review of denials of eligibility and/or of claims for benefits under the Program. The primary enrollee will be given adequate notice by the carrier, in writing, of the specific reasons for the denial, will be referred to the Program provisions on which the denial is based and an explanation of additional information required from, or on behalf of the enrollee for reconsideration of the claim. An enrollee will be given an opportunity for a full and fair review of a decision by the Plan Administrator denying eligibility for coverage under the Program or a claim for benefits under the Basic Medical Plan (BMP), Enhanced Medical Plan (EMP), Comprehensive Health Savings Plan (CHSP), or Point of Service Plan (POS) options. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the enrollee will be provided either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the enrollee upon request. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the enrollee will be provided either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the enrollee's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

For purposes of deciding appeals, the carrier responsible for administering the coverage, or responsible for administering Program eligibility, as applicable, is the delegate of the Named Fiduciary. Such delegates have discretionary authority to interpret and apply the Program on behalf of the Corporation. The individual or individuals at the carrier who decide the appeal will not be the individual who made the adverse benefit determination

that is the subject of the appeal, nor the subordinate of such individual. The review will not afford deference to the initial adverse benefit determination. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the carrier shall:

(1) consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(2) provide for the identification of medical or vocational experts whose advice was obtained on behalf of the carrier in connection with the primary enrollee's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and,

(3) provide that the health care professional engaged for purposes of the consultation referenced above shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

After the primary enrollee receives notice that a claim was denied, in whole or in part, the enrollee has at least 180 days to make a written request to the applicable carrier to have the claim reviewed. If a claim meets the definition for urgent care under applicable federal regulations, the request may be submitted by telephone.

As part of the review, the enrollee may submit any written comments that may support the claim. A written decision on the request for review will be furnished to the primary enrollee as follows:

Urgent Care Claims - In the case of a claim involving urgent care, as defined by applicable regulations, the carrier shall notify the primary enrollee of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the primary enrollee's request for review of an adverse benefit determination.

Pre-service Claims – In the case of a pre-service claim, as defined by applicable regulations, the carrier shall notify the primary enrollee of the benefit determination on review within a reasonable period of time, appropriate to the medical circumstances, but not later than 30 days after receipt by the carrier of the primary enrollee's request for review of an adverse benefit determination. In the case of a carrier that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the carrier of the primary enrollee's request for review of the adverse benefit determination.

Post-service Claims - In the case of a post-service claim, as defined by the applicable regulations, the carrier shall notify the primary enrollee of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt by the carrier of the primary enrollee's request for review of an adverse benefit determination. In the case of a carrier that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the carrier of the primary enrollee's request for review of the adverse benefit determination.

The time periods specified for each category of claims above may be extended in accordance with applicable regulations.

The written decision on the review will include the specific reasons for the decision and will set forth specific reference to Program provisions upon which the decision is based. If the review by the carrier results in an adverse determination, the primary enrollee may initiate an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

(c) As an alternative to immediately initiating such civil action, a primary enrollee receiving a final determination denying eligibility for coverage under the Program or a claim for benefits may request further review by the Plan Administrator under a voluntary review process. In connection with an applicable voluntary review process, the Program:

(1) Waives any right to assert that a primary enrollee has failed to exhaust administrative remedies because the primary enrollee did not elect to submit a benefit dispute to such process; and,

(2) Agrees that any statute of limitations or other defense based on timeliness is tolled during the time such review is pending.

(d) If a claim for benefits in excess of $1,000 under the BMP, EMP, CHSP, or POS has not been approved on the basis that the Control Plan has determined that a service, supply, device or drug therapy is research, experimental or investigational in nature, the enrollee may request a review by an independent panel of three physicians who are recognized experts in the specialty at issue. In the event that such a review is conducted, the panel participants will be selected by parties independent of the Corporation and the carrier. At the Program's expense, the panel will review the case and, applying the standard of generally accepted medical practice, will determine whether the service, supply, device or drug therapy is research, investigational or experimental in nature as defined under the Program in the individual case under appeal. If at least two of the three physicians on the panel concur on a decision, that shall be the determination of the panel. The panel's decision shall be the final determination under the Program for the case under review and shall be binding on the enrollee and the Corporation. The panel's decision shall not be considered as precedent for any other case.

(e) If the enrollee believes a decision of the Plan Administrator is inconsistent with the terms of the Program, an appeal may be filed with the Employee Benefit Plans Committee (EBPC) of the Corporation, which has been delegated final discretionary authority to construe, interpret, apply and administer the Program, which includes making factual determinations. Such an appeal to the EBPC must be filed in writing within 60 days from the date of the written decision from the Plan Administrator denying a claim for benefits or eligibility for coverage under the Program. Such an appeal may be initiated by forwarding the request to the Secretary, EBPC, Delphi Corporation, Mailcode: 480-410-104, 5825 Delphi Drive, Troy, Michigan 48098. As part of the appeal, the enrollee must submit any written comments setting forth the basis for the belief that the Plan

Administrator's decision is inconsistent with the terms of the Program. The EBPC shall be the final review authority with respect to appeals and its decision shall be final and binding upon the Corporation and any enrollee. A written decision on the request for review will be furnished to the primary enrollee within 60 days (120 days if special circumstances require an extension of time) after the date the written request is received by the EBPC.

(f) No action or suit at law by an enrollee for entitlement to benefits under this Program may be brought more than one year after the exhaustion of the mandatory or voluntary review process whichever is later as described in Article I, Section 6.

(g) If enrollees under the Health Maintenance Organization (HMO) option or an Alternative Dental Plan (ADP) wish to appeal a decision with regard to any issue, other than eligibility for coverage under the Program, they must follow the HMO's or ADP's exclusive review procedure. HMOs and ADPs are responsible for formulating their own medical policy. Decisions resulting from their appeal processes regarding medical policy are final and binding and will be given full force by the Plan Administrator. Such a decision by an HMO or ADP shall not be considered a modification to the Program.

Section 7. Coordination of Benefits (COB)

(a) General Provisions

Health care benefits paid under this Program shall not duplicate benefits from other sources (e.g., group plans, comprehensive plans, pre-paid plans, governmental plans, etc.) nor serve to relieve other persons or organizations of their liability (contractual or otherwise). Consistent with these objectives, the Corporation may establish systems and procedures for coordination of benefits, and the carriers shall implement such systems and procedures.

(b) Applicability

(1) The provisions of this Section shall apply to all coverages provided under the Program. Unless precluded by law, these provisions apply whether the coverage is self-funded, or provided through pre-paid options such as health maintenance organizations.

(2) This Program shall not coordinate with individual or family policies of insurance purchased by the enrollee or with any group policy covering the enrollee for which the enrollee pays more than one-half the cost.

(3) The provisions of this Section shall not apply to expenses for services provided to or for an enrollee in relation to any condition, disease, illness or injury arising out of or in the course of employment, as such expenses are specifically excluded from the Program.

(4) The provisions of this Section do not apply to Medicaid. They also do not apply to Medicare or to any plan, program or policy to which Medicare is secondary by operation of law (including, without limitation, automobile insurance coverage). Medicare and such plans, programs or policies are governed by App. A, II.E. These COB provisions do apply to complementary plans, programs or policies (other than those just described) which are carried to supplement benefits available under Medicare and which are secondary to it.

(c) Enrollee Obligations

(1) Primary enrollees shall furnish to the Corporation the social security numbers of all secondary enrollees for whom they are claiming eligibility. If the secondary enrollee has not been assigned a social security number at the time of enrollment, a social security number shall be obtained promptly and reported to the Corporation. Failure to do so shall result in cancellation of coverages for such secondary enrollee.

(2) Any enrollee claiming benefits under this Program shall furnish the Corporation or the carrier(s) any information the Corporation or carrier deems necessary for the purpose of administering these provisions. Failure to do so may result in non-payment of benefits.

(d) Release of Information

(1) The Program or carriers may release to other plans or carriers information necessary to

adjudicate claims under these provisions, as permitted by applicable regulations.

(2) The Program or carriers under this Program may participate in and may exchange information relating to enrollees for such purposes.

Such organizations must agree not to release any information obtained other than for the purpose of effectuating COB.

(e) Determining Priority

(1) The program which, under the rules of this subsection, has the first obligation to pay benefits is termed the "primary" program, and the coverages it provides are "primary." The other program (and the coverages it provides) is termed "secondary."

(2) When the other program does not contain a COB provision, that program is always primary.

(3) When the other program contains a COB provision and the order of benefit determination under each program's COB provisions establishes this Program as primary, the provisions of this Program determine this Program's liability, regardless of any payment the other program may have made.

(4) When the other program contains a COB provision, the following order of benefit determination will be used.

(i) The program covering the enrollee as an employee or retiree will be primary over the program covering the enrollee as a dependent; except that, if the enrollee is also a Medicare beneficiary and as a result of a rule established by Federal law Medicare is

(a) Primary to the program covering the enrollee as an employee or a retired employee, but

(b) Secondary to the plan covering the enrollee as a dependent, then the program covering the enrollee as a dependent shall be primary, Medicare shall be secondary and the program

covering that enrollee as an employee or retiree shall determine its liability last.

(ii) When the enrollee is a dependent child whose parents are not divorced or separated, the program covering the enrollee as a dependent of the parent whose birthday occurs earlier in the calendar year will be primary over the program covering the enrollee as a dependent of the parent whose birthday occurs later in the calendar year. If the two parents' birthdays fall on the same day, the program, which has covered the parent for the longer period of time, will be primary.

(iii) When the enrollee is a dependent child whose parents are divorced or separated, and if there is a court order establishing financial responsibility with respect to health care expenses of the child, the program which covers the child as a dependent of the parent with such responsibility shall be primary. If there is no court order, and the parent having custody of the child has not remarried, the program covering the child as a dependent of the parent with custody shall be primary. If there is no court order and if the parent having custody has remarried, the program covering the child as a dependent of the parent having custody shall be primary, any program covering the child as a dependent of the stepparent shall be secondary, and the program covering the child as a dependent of the parent without custody shall be last in responsibility for payment.

(iv) when rules (i), (ii), and (iii) above do not establish an order of benefit determination, the program which has covered the enrollee for the longer period of time will be primary.

However, if one program covers the enrollee as an active employee (or dependent of such employee) and the other covers the enrollee as a laid-off or retired employee (or dependent of such employee), the program covering the enrollee as an active employee

(or dependent of such employee) shall be primary.

(f) Payment of Benefits

(1) If this Program is primary, a carrier may reimburse a secondary program for any amounts paid by such program which should have been provided by this Program.

(2) If benefits under this Program are overpaid by a carrier for any claim involving COB, the carrier shall have the right to recover such overpayment, on the Corporation's behalf, from the hospital, physician, or other provider of service, from the other program, or from the primary enrollee, as appropriate. Alternatively, the Corporation may recover on its own behalf, under Section 9 below.

(3) With regard to any claim for which this Program has secondary liability, benefits provided under this Program shall not exceed the amount of benefits payable if this Program had been primary.

(4) "Benefits paid or payable" under another program include the benefits that would have been payable had a claim been made under the primary program, or which would have been payable by the primary program but for the enrollee's failure to comply with the provisions of such program. When a program provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be a benefit payable by such program.

(5) When this Program is secondary,

(i) sanctions provided under this Program (e.g., for failure to obtain predetermination, for failure to obtain a required second opinion, for failure to obtain services from a panel provider, etc.) will not apply,

(ii) payment will not exceed the amount which would have been paid by this Program had it been primary,

(iii) if the primary program's paid or payable benefits are equal to or greater than the maximum amount this Program would have paid

if primary, then the Program will not pay an outstanding balance, if any; however, the enrollee will receive credit toward any deductible and/or copayment to the extent such deductible and/or copayment would have been applied if the Program had been primary,

(iv) no payment will be made for services, which are not covered under this Program,

(v) the enrollee may be required to provide information concerning the primary program's payment or disposition prior to payment of benefits under this Program, and

(vi) if the other plan or program does not follow the same order of benefit determination rules set forth in subsection (e), above, and as a result both plans or programs take a secondary position, the Program may pay benefits not exceeding the amount it would have paid had it been the primary plan or program, but such payment shall be without prejudice to the secondary position of the Program, and the Program shall pursue recovery from the other plan or program and shall be subrogated to all rights of the enrollee against the other plan or program.

Section 8. Reimbursement for Third Party Liability

(a) If health care benefits are paid to, or on behalf of, an enrollee and if the enrollee makes recovery from a third party, individual or organization for any covered expenses for which benefits were paid, the Program shall be entitled to reimbursement in an amount equal to the benefits paid to, or on behalf of, the enrollee under this Program. This shall not apply to policies of insurance issued to and in the name of such enrollee. Carriers administering the Program shall take such actions as may be necessary to preserve or assert such right of reimbursement on the Program's behalf.

(b) The enrollee shall provide notice to the carriers (on behalf of the Corporation) of any such recovery (or effort to recover) from a third party, and shall perform such acts and execute and deliver to the Corporation or the carrier such instruments and papers

as may be necessary or helpful to secure such rights of reimbursement. These obligations include the following:

(1) The Corporation assumes the enrollee's right to recover payment from any third party, up to the extent of such third party's liability.

2) If an enrollee recovers any monies through lawsuit, settlement or other means, the enrollee must reimburse the Corporation for benefits paid.

(3) The enrollee grants the Corporation a lien on any monies the enrollee or the enrollee's beneficiaries may recover, either through settlement or otherwise, whether the recovery is designated economic or non-economic damages.

(4) The enrollee grants the Corporation the right to intervene in a lawsuit for the purpose of enforcing the Corporation's lien.

(5) The enrollee grants the Corporation the right to recover its legal fees and exceed the Corporation's payment of benefits from any recovery.

(6) The enrollee agrees to inform the Corporation when the enrollee engages an attorney to pursue a claim, and to inform the enrollee's attorney of the Corporation's rights under this Program.

(7) The enrollee agrees not to settle any claim or take any would prejudice the Corporation's rights or interests.

Section 9. Recovery of Benefit Overpayments

If it is determined that any benefit(s) paid to, or on behalf of, an enrollee under this Program should not have been paid or should have been paid in a lesser amount, written notice thereof shall be given to the applicable primary enrollee and such primary enrollee shall repay the amount of the overpayment.

If the primary enrollee fails to repay such amount of overpayment promptly, the Corporation shall arrange to recover the amount of such overpayment by making an appropriate deduction or deductions from any monies then payable, or which may become payable, by the Corporation or on the Corporation's behalf, or otherwise, to the primary enrollee in the form of salary, benefits or other compensation. The Corporation shall have the right, in

accordance with applicable Federal laws, to make, or to arrange to have made, deductions for recovering such overpayments from any such present or future salary, benefits or other compensation which are or become payable to such primary enrollee.

Section 10. Compliance with Federal Laws

Notwithstanding any provisions of the Program to the contrary, the Corporation shall modify administration, coverages and other terms and conditions of the Program, as necessary, to comply with applicable Federal laws and regulations.

Section 11. Protected Health Information (PHI)

(a) The Corporation will comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules for use and disclosure of PHI, effective April 14, 2003. The Corporation will also take such actions as may be necessary for continued compliance, in the event of subsequent amendment to HIPAA and/or implementation of related Federal regulations.

(b) Permitted uses and disclosures of PHI by the Corporation in its Plan Sponsor capacity are limited to those associated with sponsorship of the Program.

(c) The Program may release PHI to the Corporation in its Plan Sponsor capacity, so long as the Plan Sponsor certifies to:

(1) Not use or further disclose the PHI other than as permitted or required by subsection (b) above or as required by law;

(2) Require any agents, including a subcontractor, to whom it provides PHI, to agree, to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) In the absence of an appropriate authorization, not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Corporation, except that use or disclosure in connection with workers compensation matters will be allowed as permitted by HIPAA;

(4) Agree to report to the Program any use or disclosure of PHI that is inconsistent with the uses or disclosures provided by subsection (b) above, if and when the Plan Sponsor becomes aware of such inconsistent use or disclosure;

(5) Authorize the Program to make PHI available to enrollees as required by law;

(6) Authorize the Program to make PHI available to enrollees for amendment and to incorporate any such amendments as required by law;

(7) Authorize the Program to make available to enrollees an accounting of disclosures of PHI as required by law;

(8) Agree to make its internal practices, books, and records relating to the use and disclosures of PHI received from the Program available to the Secretary of the Department of Health and Human Services for purposes of determining the Program's compliance with HIPAA; and,

(9) If feasible, return or destroy all PHI received from the Program and which is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction infeasible.

(d) The Program establishes adequate separations from the Plan Sponsor as described in (1), (2) and (3), below.

(1) Delphi Corporation designates specific people, Authorized Employees, who may use and disclose PHI on behalf of the Program for purposes of plan administration functions. The Authorized Employees interact with certain Business Associates to perform these functions. Plan administration includes, but is not limited to, eligibility determinations, claims processing, precertification or preauthorization, billing, coordination of benefits, subrogation, business management, customer service, enrollment, audit functions, fraud and abuse detection, quality assurance and disease management. Plan administration does not include any employment-related functions or functions in connection with any other benefits or benefit plans, and the Program may not disclose PHI for such purposes

absent an authorization from an individual to whom the information pertains, except that use or disclosure in connection with workers compensation matters will be allowed as permitted by HIPAA.

(2) Access and use of PHI by Authorized Employees is limited to plan administration functions performed on behalf of the Program.

(3) Any issues of non-compliance by Authorized Employees will be investigated. For Delphi employees, non-compliance may result in disciplinary action up to and including termination of employment. In the case of contract workers or consultants, non-compliance may result in termination of the contract.

(e) The Program may use and disclose PHI as described in (1), (2), (3) and (4) below.

(1) The Program may disclose PHI to the Corporation in its capacity as Plan Administrator, to carry out plan administration functions consistent with subsection (d).

(2) The Program may disclose PHI to the Plan Sponsor only if an applicable notice of privacy practices with a provision permitting such disclosure has been provided to enrollees.

(3) In the absence of an appropriate authorization, the Program may not disclose PHI to Delphi Corporation for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Corporation, except that use or disclosure in connection with workers compensation matters will be allowed as permitted by HIPAA.

(4) Access to PHI is restricted to persons who need it to carry out their job duties in administering the Program. Use and disclosure is limited to the amount reasonably necessary to accomplish the intended purpose.

(f) The Program may disclose Summary Health Information to the Corporation in its Plan Sponsor capacity for the purpose of:

(1) Obtaining premium bids from health plans for providing coverage under the program; or

(2) Modifying, amending, or terminating the Program.

Section 12. Miscellaneous Administrative Rules and Procedures

Administration of Deductible, Copayment and Out-of-Pocket Maximum

The Program may include enrollment options as defined in Article II that require the primary enrollee to share a portion of covered expense as deductibles, copayments or out-of-pocket maximums.

(a) The application of these deductibles, copayments and out-of-pocket maximums shall be based only on the expense covered by the Program, regardless of the amount which actually may be charged.

(b) In the event of a continuous admission that commences in one year and continues into the next, the enrollee liability for the related facility charges will be determined on the basis of the calendar year in which the admission commences. The enrollee liability for all other charges will be based on the date services are rendered.

(c) In the event that, during a calendar year, the primary enrollee:

(1) moves from one self-insured option to another self-insured option pursuant to Article II, Section 4 of this Program, or

(2) has a carrier change for the option(s) elected,

any amounts credited toward out-of-pocket maximums for the calendar year under prior option(s) will be credited toward meeting the deductible, copayment and out-of-pocket maximum requirements of the new option(s) elected. Any applicable Program maximums will be addressed in the same manner.

ARTICLE II

HEALTH CARE COVERAGES

Section 1. Establishment of Health Care Coverages

Only to the extent and under the terms such benefits continue to be provided under this Program, as it may be amended from time to time, the Corporation will make the following available:

(a) Core Coverages

The Corporation makes available core coverages as set forth in Appendices A, B and E.

(b) Non-Core Coverages

The Corporation makes available non-core coverages as set forth in Appendices C and D.

(c) Sub-Plans

The Corporation makes available certain sub-plans such as the International Health Care Plan.

Section 2. Uniform National Health Care Coverages

(a) The Corporation shall provide health care coverages, nationwide, as described in this Program, under a national system by agreement between the Corporation and Blue Cross and Blue Shield of Michigan, hereinafter referred to as the Control Plan, or by agreement with other carriers.

(b) The Control Plan shall have responsibility for overseeing the carriers administering the core coverages described in Appendix A for Basic Medical Plan, Enhanced Medical Plan, Comprehensive Health Savings Plan and Point-of-Service option enrollees.

(c) All carriers agreeing to provide coverages under the Program shall do so in accordance with the Program provisions and interpretations and benefit practices established by the Control Plan, as applicable.

(d) Under the national system each carrier with a written agreement with the Control Plan will provide the core coverages described in Appendix A in the carrier's respective geographic area. If in any geographic area

such a carrier fails to enter into the agreement as stated above, or fails to perform in accordance with its agreement, the Control Plan, with the approval of the Corporation, may arrange for the provision of such health care coverages in the geographic area through alternative means.

(e) Coverage may be provided through the Health Maintenance Organization option. However, the coverages provided through this option may vary from the coverages described in Appendices A and B.

Section 3. Replacement or Supplementation of Coverages

If, in its judgment, the Corporation considers it advisable, another arrangement may be substituted, in any geographic area, for all or part of the coverages referred to in Section 1 above.

Section 4. Selection of Option

The Corporation provides an opportunity for primary enrollees (other than those primary enrollees set forth in subsection (e) below) to elect coverages through the options available under the Program. This includes enrollees residing in Puerto Rico. Such election also may include a choice among dental options, where applicable. The specific choices offered to a primary enrollee will depend on the primary enrollee's service date, status, the availability of approved options in the enrollee's geographic area, and the Medicare status of the primary and secondary enrollees.

The medical options offered to primary enrollees may include (a) Health Maintenance Organization (HMO), (b) Basic Medical Plan (BMP), (c) Enhanced Medical Plan (EMP)(d) Point of Service (POS) and (e)Comprehensive Health Savings Plan options.

(a) Health Maintenance Organization (HMO) Option

This option provides core coverages (other than Extended Care Coverage) to enrollees through physicians, hospitals, and other providers who have agreed to provide services under the terms established by the health maintenance organization to limit fees, assure quality, and control utilization. Extended Care Coverage, under Appendix E, is available to enrollees of this option.

(1) The types of coverages and the scope and level of coverages provided under this option may vary

among health maintenance organizations and may be different than the coverages set forth in Appendices A and B.

(2) Most health maintenance organizations provide health care coverages (including preventive care) that generally are managed for the enrollee by a primary care physician. The primary care physician is responsible for referring the patient to other providers of service. If such referral is not obtained, the enrollee may be responsible for charges incurred.

(3) Under this option, if an enrollee receives services from a non-health maintenance organization provider, in a non-emergency situation or without a referral, such services may not be covered.

(b) Basic Medical Plan (BMP) Option

This option provides the core coverages described in Appendix A through access to a network of providers within a defined service area who have agreed to provide services under the terms of participation established by the Basic Medical Plan carriers. Mental health and substance abuse care for enrollees of this option are provided under Appendix B. Extended Care Coverage, under Appendix E, is available to enrollees of this option. Core coverages (other than certain screening and certain diagnostic tests/examinations, durable medical equipment and prosthetic and orthotic appliances, and prescription drug coverage as set forth in Appendix A and those core coverages under other appendices) are subject to a $900 individual and $1,800 family calendar year deductible. No more than $900 for an individual may be counted toward satisfying the family deductible, but the family deductible may be met without any individual meeting the individual deductible amount. After the deductible is satisfied, a 25% copayment is required for covered expenses (other than those exempted from the deductible above) received in network, up to a calendar year combined maximum out-of-pocket expense for deductibles and copayments of $2,500 for an individual and $5,000 for a family. For covered expenses (other than those exempted from the deductible above) received out-of-network, a 40% copayment is required after the deductible is satisfied, and the combined maximum out-of-pocket expense for deductibles and copayments does not apply.

(1) The Basic Medical Plan carriers assume responsibility for conducting utilization reviews, predetermination of services, or other reviews necessary to promote quality of care and control costs where responsibility has not been assigned by the Corporation to another party. The carrier may place the participating physician at financial risk through capitation, withholding of a percentage of fees, or other mechanisms, or if not, will have other means to monitor and control utilization by individual providers on a continuous basis. (See Appendix A, II.K. for predetermination and other review requirements, including provisions that impact benefit payment.)

(2) The Basic Medical Plan carriers assume responsibility for selection and periodic evaluation of hospitals, physicians, laboratories, and other providers to ensure sufficient numbers and types of providers who are geographically distributed to allow adequate access for enrollees within a service area as defined by the carrier.

(3) The Basic Medical Plan carriers assume responsibility for providing the scope and level of benefits set forth in Appendix A, monitoring the appropriateness of referrals to nonparticipating providers, taking affirmative corrective action with respect to providers when necessary, and implementing and maintaining other administrative processes as required by the Corporation.

(4) Maximum benefits are available only if the services are rendered by participating providers.

This option contains predetermination and review procedures required in order to receive maximum benefits for certain covered services. (See Appendix A, II.K. for predetermination and other review requirements, including provisions which impact benefit payment.)

The prescription drug coverage outlined in Appendix A will be delivered through a separate pharmacy network and the co-pay amounts are separate from the other cost sharing outlined in this Article II.4.(b). Refer to Appendix A, III.G.

(c) Enhanced Medical Plan (EMP) Option

This option provides the core coverages described in Appendix A through access to a network of providers within a defined service area who have agreed to provide services under the terms of participation established by the Enhanced Medical Plan carriers. Mental health and substance abuse care for enrollees of this option are provided under Appendix B. Extended Care Coverage, under Appendix E, is available to enrollees of this option. Core coverages (other than certain screening and certain diagnostic tests/examinations, durable medical equipment and prosthetic and orthotic appliances, and prescription drug coverage as set forth in Appendix A and those core coverages under other appendices) are subject to a $450 individual and $900 family calendar year deductible. No more than $450 for an individual may be counted toward satisfying the family deductible, but the family deductible may be met without any individual meeting the individual deductible amount. After the deductible has been satisfied, a 20% copayment will be required for covered expenses (other than those exempted from the deductible above) received in network, up to a calendar year combined maximum out-of-pocket cost for deductibles and copayments of $2,000 for an individual and $4,000 for a family. For covered expenses (other than those exempted from the deductible above) received out-of-network, a 40% copayment is required after the deductible is satisfied, and the combined maximum out-of-pocket expense for deductibles and copayments does not apply.

(1) The Enhanced Medical Plan carriers assume responsibility for conducting utilization reviews, predetermination of services, or other reviews necessary to promote quality of care and control costs where responsibility has not been assigned by the Corporation to another party. The carrier may place the participating physician at financial risk through capitation, withholding of a percentage of fees, or other mechanisms, or if not, will have other means to monitor and control utilization by individual providers on a continuous basis. (See Appendix A, II.K. for predetermination and other review requirements, including provisions that impact benefit payment.)

(2) The Enhanced Medical Plan carriers assume responsibility for selection and periodic evaluation of hospitals, physicians, laboratories, and other providers to ensure sufficient numbers and types of providers who are geographically distributed to allow adequate access for enrollees within a service area as defined by the carrier.

(3) The Enhanced Medical Plan carriers assume responsibility for providing the scope and level of benefits set forth in Appendix A, monitoring the appropriateness of referrals to nonparticipating providers, taking affirmative corrective action with respect to providers when necessary, and implementing and maintaining other administrative processes as required by the Corporation.

(4) Maximum benefits are available only if the services are rendered by participating providers.

This option contains predetermination and review procedures required in order to receive maximum benefits for certain covered services. (See Appendix A, II.K. for predetermination and other review requirements, including provisions which impact benefit payment.)

The prescription drug coverage outlined in Appendix A will be delivered through a separate pharmacy network and the co-pay amounts are separate from the other cost sharing outlined in this Article II.4.(c). Refer to Appendix A, III.G.

(d) Point of Service (POS) Option

(1) This option provides core coverages (with the exception of Extended Care Coverage for enrollees whose service date is on or after January 1, 2001) to enrollees through physicians, hospitals, and other providers who have agreed to provide high quality, cost-effective services under the terms established by the POS Plan.

(2) The covered services outlined in Appendix A and B will be provided through the various POS plans. In some instances, additional covered services, such as allergy testing and treatment, or a greater number of home health care visits, may be available

within the POS network because of favorable contracts with providers.

(3) POS plans provide health care coverage (including preventive care) that is managed for the enrollee by a primary care physician. The primary care physician is responsible for referring the patient to other providers of service.

(4) Covered services received in-network have the following co-pay requirements:

(i) $25 per office visit to a primary care physician and $35 per office visit to a specialist (this includes outpatient mental health services, as well as outpatient physical, speech or occupational therapy);
(ii) $100 for the use of an emergency room and $50 for the use of an urgent care facility (this co-pay is waived if the enrollee is admitted to the hospital);
(iii) $150 for each outpatient surgical facility admission; and
(iv) $350 for each facility admission.

(5) Covered services, with the exception of mental health and prescription drug services, received out-of-network are subject to an out-of-network deductible and copayment. The calendar year deductible is $500 for an individual and $1,000 for a family. No more than $350 for an individual may be counted toward satisfying the family deductible, but the family deductible may be met without any individual meeting the individual deductible amount. After the deductible is satisfied, a 20% copayment is required for covered expenses up to a calendar year combined maximum out-of-pocket expense for deductibles and copayments of $2,500 for an individual and $5,000 for a family.

(6) If an enrollee receives a covered service in a non-emergency situation, without a referral from their primary care physician or the carrier, the services will be considered out of network and will be subject to the cost-sharing provisions contained in subsection (d)(5) above. Certain services are only covered if received in-network and from an approved provider. Those services and supplies that are not covered if received out-of-network include: hearing aid services, home health care, durable medical

equipment, prosthetic and orthotic appliances, and substance abuse treatment. In addition, mental health services received out of network will only be covered when rendered by a qualified physician or facility.

(7) In order to receive maximum benefits for covered services, such services must be obtained within the POS network of providers through the enrollee's primary care physician.

(8) Network benefits are available when provided by non-network providers if such services are on referral from the primary care physician and approved by the POS, subject to the conditions below.

(i) The primary care physician is responsible for communicating the referral to the carrier and monitoring the progress of the patient. The primary care physician must make any subsequent referrals.

(ii) The carrier is responsible for monitoring referral frequency and patterns, and for ensuring that additional costs are not incurred by the Program or the enrollee.

(iii) A service, which would not otherwise be a covered service, does not become a covered service by virtue of a referral.

(iv) Payment for a covered service received out-of-network (A service is considered out-of-network if it is performed by a provider other than the primary care physician (PCP) without a referral by the PCP or the carrier and the event requiring the service is not an emergency as determined by the carrier.), will be equal to 80% of the POS carrier's network reimbursement for the same service or, if less, 80% of the actual charge, after any remaining deductible is satisfied. The enrollee will be responsible for the difference between the POS carrier's network reimbursement for the out-of-network service and the provider's charge. The amount of any charges in excess of the POS network reimbursement will not be applied to the $2,500 individual or $5,000 family out-of-pocket maximum.

(v) Mental health services received out-of-network by a physician are only covered at 50% of the POS carrier in-network reimbursement and are not subject to the out-of-network deductible. The amount of any charges in excess of the POS carrier in-network reimbursement will not be applied to the $2,500 individual or $5,000 family out-of-pocket maximum.

(9) The prescription drug coverage outlined in Appendix A will be delivered through a separate pharmacy network and the co-pay amounts are separate from any other cost sharing outlined in Article II.4.(d). Refer to Appendix A, III.G.

(10) A POS carrier assumes responsibility for conducting utilization reviews, predetermination of services, or other reviews necessary to promote quality of care and control costs, where responsibility has not been assigned by the Corporation to another party. A POS carrier may place the primary care physician and other providers at financial risk through capitation, withholding of a percentage of fees, or other mechanisms, or if not, will have other means to monitor and control utilization by individual providers on a continuous basis. (See Appendix A, II.K. for predetermination and other review requirements.)

(11) A POS carrier assumes responsibility for selection and periodic evaluation of hospitals, physicians, laboratories, and other providers to ensure sufficient numbers and types of providers who are geographically distributed to allow adequate access for enrollees.

(12) A POS carrier assumes responsibility for providing the scope and level of benefits set forth in Appendix A and Appendix B, monitoring the appropriateness of referrals to non-panel providers, taking affirmative corrective action with respect to providers when necessary, and implementing and maintaining other administrative processes as required by the Corporation.

(13) A POS carrier may seek Corporation approval to establish special contractual relationships with providers not otherwise included under the Program when it can be shown that doing so will improve quality of care and enhance cost competitiveness.

(e) Comprehensive Health Savings Plan (CHSP) Option

This option is intended to satisfy the criteria established under Federal regulations to be a "high deductible health plan". This option provides the core coverages described in Appendix A through access to a network of providers within a defined service area who have agreed to provide services under the terms of participation established by the Comprehensive Health Savings Plan carrier. Mental health and substance abuse care for enrollees of this option are provided under Appendix B. Extended Care Coverage, under Appendix E, is available to enrollees of this option. Core coverages (other than certain screening and diagnostic tests/examinations and certain prescription drugs) are subject to a $1,200 individual and $2,400 family calendar year deductible. The family deductible may be met without any individual meeting the individual deductible amount; however, if an enrollee elects other than "self only" coverage, the full family deductible must be met before the CHSP will pay any benefits. After the deductible is satisfied, a 20% copayment is required for covered expenses (other than those exempted from the deductible above) received in network, up to a calendar year combined maximum out-of-pocket expense for deductibles and copayments of $2,500 for an individual and $5,000 for a family. For covered expenses (other than those exempted from the deductible above) received out-of-network, a 40% copayment is required after the deductible is satisfied, and the combined maximum out-of-pocket expense for deductibles and copayments does not apply.

(5) The Comprehensive Health Savings Plan carriers assume responsibility for conducting utilization reviews, predetermination of services, or other reviews necessary to promote quality of care and control costs where responsibility has not been assigned by the Corporation to another party. The carrier may place the participating physician at financial risk through capitation, withholding of a percentage of fees, or other mechanisms, or if not, will have other means to monitor and control utilization by individual providers on a continuous basis. (See Appendix A, II.K. for predetermination and other review requirements, including provisions that impact benefit payment.)

(6) The Comprehensive Health Savings Plan carriers assume responsibility for selection and periodic

evaluation of hospitals, physicians, laboratories, and other providers to ensure sufficient numbers and types of providers who are geographically distributed to allow adequate access for enrollees within a service area as defined by the carrier.

(7) The Comprehensive Health Savings Plan carriers assume responsibility for providing the scope and level of benefits set forth in Appendix A, monitoring the appropriateness of referrals to nonparticipating providers, taking affirmative corrective action with respect to providers when necessary, and implementing and maintaining other administrative processes as required by the Corporation.

(8) Maximum benefits are available only if the services are rendered by participating providers.

This option contains predetermination and review procedures required in order to receive maximum benefits for certain covered services. (See Appendix A, II.K. for predetermination and other review requirements, including provisions which impact benefit payment.)

The prescription drug coverage outlined in Appendix A will be delivered through a separate pharmacy network and the co-pay amounts are outlined in Appendix A, III.G. Such co-pays will apply after the deductible has been met.

(f) Options Available to U.S. Expatriates, Certain Foreign Nationals, Flexible Service Employees, Cooperative Students, Employees Working in Hawaii and Primary Enrollees Who Reside in Canada

Unless otherwise noted, employees classified as Expatriates, or Cooperative Students and employees working in Hawaii are not eligible to elect the medical care options described in subsections (a), (b), (c), (d)or (e) above. Coverages for such employees are described below:

(1) U.S. Expatriates and certain Foreign Nationals

Except for employees assigned to Canada and continuing to reside in the United States (who

are limited to the coverages and options applicable to salaried employees of United States operations who reside in the United States), employees classified as U.S. Expatriates and certain foreign nationals are eligible for the coverage provided under the International Health Care Plan (IHCP). The IHCP provides Core and Non-Core coverages similar, but not necessarily equivalent to those coverages provided for eligible U.S. employees. Extended Care Coverage is not available. (Predetermination and review requirements set forth in Appendix A, II.K. do not apply.)

(2) Flexible Service Employees

Flexible Service Employees are eligible for the options described in this Section 4 based on their date of service.

(3) Cooperative Students

Employees classified as Cooperative Students are not eligible for coverage under the Program.

(4) Employees Working in Hawaii

The Corporation will make arrangements for primary enrollees (who are not retired or a surviving spouse), who live in Hawaii and are eligible for Corporation contributions for health care, for a health care plan that meets the requirements of Hawaii state law. The health care available to Hawaiian employees will provide Core and Non-Core coverages similar, but not necessarily equivalent, to those coverages provided to other eligible U.S. employees. Such primary enrollees will also be eligible for Extended Care Coverage. The provisions of this sub-section do not apply to retirees or surviving spouses residing in Hawaii.

(5) Primary Enrollees Who Reside in Canada

The Corporation may make arrangements for primary enrollees, who live in Canada and are eligible for Corporation contributions for health care, to elect, on an optional basis, a Canadian based health care plan that provides hospital, surgical, medical, prescription drug, hearing aid, dental, vision, mental health and substance abuse coverages, and/or other coverages similar,

but not necessarily equivalent to those coverages provided for eligible U.S. employees. Extended Care Coverage is not available. (Predetermination and review requirements set forth in Appendix A, II.K. do not apply.)

The Canadian coverages, if elected, will be in lieu of coverages available at the U.S. location where employed or from which retired. Such election shall remain in effect while the primary enrollee remains a resident of Canada.

ARTICLE III

ENROLLMENT, ELIGIBILITY, COMMENCEMENT, CONTRIBUTIONS AND CONTINUATION

Section 1. Enrollment

(a) An eligible primary enrollee must complete and sign an application for the coverages in which the enrollee elects to participate. The application or enrollment form shall include an authorization for payroll or retirement check deductions for contributions which may be required. Once signed, such authorization will remain in effect until revoked in writing by the primary enrollee. A primary enrollee not making an election, completing an application or authorizing deductions (enrollee contributions) may be assigned to an option by the Corporation or may have coverage suspended pending such election, application or authorization.

(1) At the primary enrollee's option such coverage may include the following enrollment classifications: (i) self only, (ii) self and spouse, (iii) self and child (children), or (iv) self and family. For primary enrollees whose coverages cease in accordance with Article III, Section 5(e), the following enrollment classifications may be available, depending on any secondary enrollee's eligibility: (v) spouse only, (vi) spouse and child(children), or (vii) child (children) only. For purposes of enrollee contributions, family coverage shall include only spouse and eligible children as defined in Section 8 of this Article.

(2) Primary enrollees who are employees eligible for all coverages under the Program and participate in the Flexible Benefits Program may elect (i) core coverages alone, (ii) core coverages plus any or all non-core coverages, (iii) any or all non-core coverages without core coverages, (iv) to "opt out" of some or all coverages and have "benefit dollars" applied to other benefits or (v) to waive all coverages to be enrolled as a dependent of another primary enrollee. Those who opt out of or waive coverage may be subject to restrictions on re-enrollment.

(3) Primary enrollees who are retirees or surviving spouses may elect (i) core coverages alone, (ii) core coverages plus any or all non-core coverages, (iii) any or all non-core coverages without core coverages, (iv) to waive coverage to be covered as a dependent of another primary enrollee or (v) reject coverages. Waiving or rejecting coverage may result in restrictions on re-enrollment. Retirees and surviving spouses must elect Medical Plan coverage in order to have Extended Care Coverage, but may decline Extended Care Coverage while retaining Medical Plan coverage. However, if they do so, they may be ineligible to participate in it at a later date. Also, retirees and surviving spouses who are eligible to continue participation in the Program only on a self-paid basis will not be permitted to enroll/reenroll if they do not elect to enroll when first eligible or initially enroll, but have coverage discontinued for failure to make the required contributions.

(4) The primary enrollee's election shall apply to all dependents.

(5) When a husband and wife both qualify as primary enrollees, each may make a separate election. However, no individual may have coverage as both a primary and a secondary enrollee, nor as a secondary enrollee under more than one primary enrollee.

(6) If a primary enrollee's coverage otherwise available under this Program is waived or canceled, and based upon such waiver or cancellation the primary enrollee receives some financial consideration from the Corporation (under this or any other Corporation plan or program), such primary enrollee shall be precluded from coverage as a secondary enrollee under another person's coverage for a period of time equal to that upon which such consideration is based. This provision also applies to secondary enrollees, if any, included in the waiver or cancellation on which such consideration is based.

(7) Retired employees or surviving spouses who are enrolled for health care coverages as provided in the Program and who have permanently changed their residence from the service area of the

carrier with which they are enrolled for such coverages, must transfer their coverages to a local carrier serving the area in which they reside.

Such transfers shall become effective the first day of the month following the receipt of the application for transfer.

(b) The primary enrollee may be required to make monthly contributions as set forth in the Program, according to the primary enrollee's status, the enrollment classification, the option elected, the Medicare status of enrollees, and the type and number of dependents enrolled.

Section 2. Dates of Eligibility, Commencement of Coverages, and Corporation Contributions for Active Employees

(a) Eligibility and Commencement of Coverages for Current and New Employees

An employee shall become eligible for certain Program coverages on January 1, 1999 or, if later, on the first day of the third month following the month of hire, provided the employee is in active service on the first working day of such month. Salaried employees who are hired on or after January 1, 2001, and whose service date is on or after January 1, 2001 shall become eligible as of their date of hire. United States salaried employees hired directly to Expatriate positions (Expatriate-U.S.) are eligible for coverage through the International Health Care Plan upon date of hire. If an employee is not in active service on the date coverages otherwise would start, coverages will become effective upon the employee's return to work.

However, for purposes of this subsection 2(a), if an employee is scheduled to be at work, but is absent due to disability, and is consequently placed on a disability leave of absence, the employee will be deemed to be in active service and at work.

(b) Eligibility and Commencement of Coverages for Employees returning to Active Work

If an employee's coverages are discontinued and the employee subsequently returns to active work, eligibility for coverages shall be determined in

subsection (a) above, except as provided in subsections (1) through (4) below.

For purposes of this subsection 2(b), if an employee is scheduled to return to work, but is unable to do so because of disability, and is consequently placed on a disability leave of absence, the employee will be deemed to have returned to work effective with the date the employee would otherwise have returned to work, but for the disability leave.

(1) Returning From Leave of Absence

If an employee's coverages were discontinued while on leave of absence and the employee returns to active work with unbroken length of service, the employee shall be eligible for health care coverages immediately on the date of return to active work with the Corporation.

(2) Returning From Separation From Service Due to a Quit or Discharge

If separation from service was due to a quit or discharge but the employee is reemployed within 31 days, the employee shall be eligible for health care coverages immediately on the date of return to active work.

(3) Returning From Separation From Service for Reason Other Than Quit or Discharge

If separation from service was due to a reason other than quit or discharge and the employee had health care coverages in effect before breaking length of service, and if the employee returns to active work within a period of 24 consecutive months, the employee shall be eligible for health care coverages immediately on the date of return to active work with the Corporation.

(4) Returning From Military Leaves of Absence

An employee reporting for work from military leave of absence in accordance with the terms of such leave shall be eligible for health care coverages as of the date the employee reports available for work.

(c) Eligibility and Commencement of Coverages for Expatriate Employees Transferring To/From Regular Active Service From/To Expatriate, or Cooperative Student Status

If an employee transfers to/from regular full-time status from/to Expatriate, or Cooperative Student status, the employee shall be eligible for health care coverages, based on the new status, effective with the first day of the month following the change of status, unless the change of status is on the first day of the month in which case the change of coverage is effective that day. However, in the case of a repatriating Expatriate employee, the effective date may be delayed one month, when appropriate, to accommodate the transition from one country and/or assignment to the next. In any event, the effective date shall be the first day of the month.

(d) Corporation Contributions for Employees in Active Service

(1) With respect to any month in which the employee is in active service with the Corporation and eligible for coverage as specified in this Section 2 as of the beginning of the month, the Corporation shall make contributions for that month's coverages as specified in the Program.

(2) With respect to any month in which an employee does not meet the requirements of subsection 2(d)(1) above by virtue of not being in active service at the beginning of the month, but in which an employee returns to work and is eligible for reinstatement of coverages under subsection 2(b) above, the Corporation shall make contributions as specified in the Program effective with the date of return to work.

(e) Certain Ineligible Individuals

The following classes of individuals are ineligible to participate in the Program, regardless of any other Program terms to the contrary, and regardless of whether the individual is a common-law employee of Delphi:

(1) Any worker who provides services to the Corporation where there is an agreement with a separate company under which the services are

provided. Such individuals are commonly referred to by the Corporation as "contract employees" or "bundled services employees."

(2) Any worker who has signed an independent contractor agreement, consulting agreement, or other similar personal services contract with the Corporation or who has represented themselves to be an independent contractor, consultant, or other similar personal service provider.

(3) Any worker that the Corporation, in good faith, classified as an independent contractor, consultant, contract employee, or bundled services employee during the period the individual is so classified by the Corporation.

The purpose of this provision is to exclude from participation in the Program all persons who may actually be common-law employees of the Corporation, but who are not paid as though they were employees of the Corporation, regardless of the reason they are excluded from the payroll, and regardless of whether that exclusion is correct.

Section 3. Continuation of Coverages During Disability Leave of Absence

(a) Health care coverages (other than dental for an approved disability leave of absence commencing prior to September 17, 1979) shall be continued for the duration of an approved disability leave of absence for employees with service dates on or before December 31, 2000 provided the employee is totally and continuously disabled and makes any required monthly contributions.

However, for employees with service dates on or after January 1, 2001, health care coverages shall be continued during an approved disability leave for up to a maximum of 29 months, provided the employee is totally and continuously disabled and makes any required monthly contributions, but in no case will health care coverage be continued beyond the end of the month in which the employee's approved disability leave ends.

(b) If an employee's disability leave is canceled because the period of such leave equaled the length of the employee's service, coverages continued while on disability leave, in accordance with subsection (a)

above, shall continue to remain in force in any month in which the employee continues to receive salary continuation, Sickness and Accident Benefits or Extended Disability Benefits in accordance with the Delphi Life and Disability Benefits Program for Salaried Employees subsequent to such cancellation. This provision is contingent upon the employee making any required monthly contribution. However, receipt of Supplemental Extended Disability Benefits or Long Term Disability Benefits subsequent to such cancellation does not extend the continuation period.

(c) The Corporation shall make contributions, in accordance with Program provisions, for health care coverages continued in accordance with subsections (a) and (b) above.

Section 4. Continuation of Coverages During Other Leaves of Absence

(a) Employees on leave of absence under the Family and Medical Leave Act (FMLA) of 1993 shall have coverages continued in accordance with the FMLA. Health care coverages for an employee on any other type of approved non-disability leave of absence shall be continued to the end of the month in which the employee is last in active service.

(b) An employee who desires to continue coverages beyond the period specified in subsection (a) above may do so, provided the employee contributes for coverage as described in (1), (2) and (3) below.

(1) Dependent Care Leave commencing on or after January 1, 1995. Employees may continue coverages for up to 24 months (including those months covered by FMLA), provided the employee pays 50% of the full monthly cost for the first 12 months and 100% of the full monthly cost thereafter. If any portion of a Dependent Care Leave is also covered by the provisions of the FMLA, the provisions of that act will apply to such portion of the leave.

(2) Educational Leave. Employees may continue coverages for the duration of such leave provided the employee pays 50% of the full monthly cost.

(3) Other Non-Disability Leaves. Coverages during all other non-disability leaves may be continued

for up to 12 months provided the employee pays 50% of the full monthly cost.

(c) As an alternative to the continuation specified in subsection (b)(3) above, employees on military leave of absence may elect to continue all coverages beyond the period specified in subsection (a) above in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994.

(d) From time to time, the Corporation may establish certain leave programs under which employees may be offered limited continuation privileges provided they make specified monthly contributions. Such programs may vary in percentage of the full cost of coverage which the employee is required to pay and in the length of the continuation period as stipulated by the leave program.

(e) If an employee has not broken service and has continued coverages as provided in subsection (b) above during an approved leave of absence other than for disability, granted because of a clinically anticipated disability based on the natural course of the employee's diagnosed condition, and presents medical certification from the employee's personal physician, satisfactory to the Corporation, that the employee is totally disabled, health care coverages shall be provided, as of the date such certification is presented, on the same basis as set forth in Section 3.

(f) The Corporation shall make contributions for health care coverages continued in accordance with subsection (e) above, on the same basis as set forth in Section 4, as of the date certification of disability is presented.

Section 5. Continuation of Coverages Upon Retirement or Termination of Employment at Age 65 or Older for Employees or Certain Former Employees

(a) An employee whose employment status is retirement as determined in accordance with Delphi policy, as may be revised from time to time, (other than a deferred vested retirement) or who terminates employment at age 65 or older (for any reason other than a discharge for cause) may continue health care coverages.

(b) Certain former employees may be eligible to enroll for health care coverages upon retirement, pursuant to specific policies established by the Corporation in connection with the acquisition or divestiture of an operation.

(1) Unless otherwise provided for in the terms of a divestiture, employees who are eligible to retire with health care in retirement on the date of sale of a divested unit are eligible to enroll for health care coverages (subject to all terms and conditions of the Program then in effect) when their employment at the successor company ceases.

(2) Employees who transferred to Inteva(as part of the divestiture of the Interiors business)

Employees with a continuous length of service date on or before December 31, 1992 but who are not eligible to retire on the date of the sale are eligible to enroll for health care coverages (subject to all terms and conditions of the Program then in effect)when their employment at Inteva ceases provided: (1) their credited service on the date of the sale when combined with their length of service at Inteva (as of their separation date at Inteva) and their age (as of their separation date at Inteva) makes them eligible for health care in retirement; and (2) Inteva has continued to reimburse Delphi for the applicable annual service cost associated with such employees' health care in retirement.

(c) An employee who upon retirement is not enrolled for the coverages as provided in subsection (a) above may enroll for health care coverages to which entitled at the time of or subsequent to retirement. Such coverage shall become effective on the first of the month following receipt of application from such retired employee.

(d) The Corporation shall make contributions, in accordance with Program provisions, for health care coverages continued in accordance with subsections (a), (b) and (c) above, except for:

(1) an employee who retires voluntarily at or after age 55 and prior to age 60, when age and credited service total less than 85;

(2) an employee who retires with less than ten years of credited service under the Delphi Retirement Program for Salaried Employees; or

(3) an employee whose continuous service with the Corporation (or an adjusted service date established in accordance with Corporation policy and procedure) commenced on or after January 1, 1993 and who retires after that date.

Individuals specified in (1), (2) and (3) above must pay the full cost in order to continue coverages. If they decline to continue, or discontinue making the required contributions, they will not be eligible to reenroll.

(e) Primary enrollees whose coverages are continued under this Section 5 may only continue such coverages until the first of the month in which they become Medicare eligible in the normal course. Thereafter, coverages (other than Dental, Vision and Extended Care Coverage) for the primary enrollee will cease.

(1) Primary enrollees, other than those specified in subsections (d)(1), (d)(2) and (d)(3) above, will be eligible for a Retiree Health Reimbursement Account (RHRA), as follows:

(i) The amount of the RHRA will be $20,000 for those primary enrollees who were classified as retired on or before March 1, 2005 and $10,000 for all other eligible primary enrollees.

(ii) The RHRA has no cash value, does not earn interest and may not be converted to cash except to reimburse the primary enrollee for certain qualified health care expenses.

(iii) Qualified health care expenses are limited to premiums paid by the primary enrollee for health care coverages for themselves and any eligible dependents (e.g., Medigap, Medicare Part D, etc.

(iv) Only a primary enrollee may be eligible for or may activate a RHRA. Secondary enrollees are not eligible for and may not activate a RHRA.

(v) Upon the death of the primary enrollee who is eligible for an RHRA, eligibility for the RHRA may be transferred to an eligible surviving spouse, as described in Section 7 (e)(5). In the event the

primary enrollee does not have an eligible surviving spouse, eligibility for and RHRA or an RHRA that has been activated is terminated.

(2) Primary enrollees whose coverages cease pursuant to this subsection (e) may continue Dental, Vision and Extended Care Coverage (if eligible) for themselves and any eligible dependents by paying the full cost of any coverages continued.

(3) Primary enrollees whose coverages cease pursuant to this subsection (e) may continue core coverages (described in Appendices A and B) for any eligible dependent who is not eligible for Medicare in the normal course by enrolling for the applicable enrollment classifications described in Article III, Section 1(a)(1) and paying the applicable contribution. Coverages for such dependents will cease when they no longer meet the dependent eligibility requirements set forth in Section 8 of this Article or, if earlier, when they become Medicare eligible in the normal course.

Section 6. Eligibility for Coverages Following Any Termination of Employment Other Than by Retirement or Death

Except as provided in Section 5, above, and in subsection (b) of this Section 6, following any termination other than by retirement or death, any health care coverages in effect shall cease automatically as of the last day of the month in which employment terminates.

(a) Following termination of employment other than by retirement or death, the former employee shall be entitled to self-paid continuation of coverages provided under applicable Federal laws (see Section 10, below), and/or may be offered a conversion contract (see Section 9, below).

(b) From time to time the Corporation may establish certain separation programs (e.g., Career Transition Program, External Opportunities Program) under which employees terminating employment may be offered limited health care coverage continuation privileges. In such cases, acceptance of Program continuation under the separation program shall be an alternative to self-paid continuation under applicable Federal laws. Employees terminating employment under such

programs must choose between Program continuation and self-paid continuation.

Section 7. Continuation of Coverages for the Survivors of Employees, of Retired Employees or of Certain Former Employees

(a) General Provisions

(1) If a primary enrollee dies after coverages are in effect under the Program, coverage for any enrolled dependents (including sponsored dependents) will cease at the end of the month in which the primary enrollee dies. Thereafter, a surviving spouse may be eligible to enroll in and/or continue coverages as provided in subsections (b) through (g), below.

(2) When an employee or retiree dies and leaves no surviving spouse eligible for coverages under this Section 7, any remaining enrolled dependents (including a spouse who is ineligible for surviving spouse coverage under this Section 7 due to having been married to the deceased employee for less than the one full year immediately preceding the date of death) whose coverage terminates at the end of the month in which the employee or retiree dies, may be eligible to continue coverages, on a self-paid basis, under applicable Federal laws (see Section 10, below) or to obtain a conversion contract (see Section 9, below).

(3) For purposes of this Section 7, "surviving spouse" does not include a former employee's spouse who is eligible only for a deferred retirement benefit under the Delphi Retirement Program for Salaried Employees; a spouse or former spouse who is receiving, or eligible to receive, a pre-retirement survivor benefit under the above referenced retirement program; or a spouse who is enrolled as a sponsored dependent. However, under this section, "surviving spouse" may apply to the spouses of certain former employees, pursuant to specific policies established by the Corporation in connection with the acquisition or divestiture of an operation as referenced in Article III, Section 5(b) and Section 6(b).

(4) Coverage which may be available under this Section 7 to a surviving spouse is available as an alternative to the continuation privilege which may be provided under Federal law (see Section 10, below). The surviving spouse must make an election no later than 60 days following the later of the end of the month in which the death of the employee or retiree occurs or the date of notice of available options by the Corporation. A surviving spouse who is ineligible for Corporation contributions and who fails to make a timely election as indicated above will not be permitted to enroll for coverage at a later date.

(5) Except as provided in Article III, Section 8(c)(2), below, a surviving spouse continuing coverage under this Section 7 may not add dependents to the coverage. Coverage may be continued for dependent children and sponsored dependents enrolled as of the decedent's date of death, subject to their continued satisfaction of Program eligibility criteria.

(6) When a surviving spouse is required to make contributions to continue coverages, the contributions shall be paid directly to the Corporation or its agent on or before the first day of the month for which such coverages are to be provided, or such other due date as may be established by the Corporation. Failure to make the required monthly contributions by the end of the month for which coverage is to be provided will result in cancellation of coverage.

(7) Once coverage is rejected, or canceled for failure to make required contributions, it may only be reinstated if the surviving spouse was not enrolled as a surviving spouse due to being enrolled as a primary or secondary enrollee under other provisions of the Program.

(b) Employees Whose Deaths Occur Prior to Becoming Eligible for Coverage Under the Program

(1) If the surviving spouse was married to the deceased employee for at least the one full year immediately preceding the date of death, and the employee dies prior to becoming eligible for coverages under the Program, the Corporation will permit the surviving spouse to enroll for core coverages on a self-paid basis.

(2) If such surviving spouse elects to enroll for coverage in accordance with subsection (b)(1) above, coverage may be continued for at least 24 months but in no event beyond the end of the month preceding the month in which the surviving spouse is eligible for Medicare in the normal course. If, as of the employee's date of death, the surviving spouse's age is at least 45 or the surviving spouse's age when added to the deceased employee's years of credited service totals 55 or more, coverage may be continued beyond the 24 months to the earliest of the surviving spouse's remarriage, attainment of age 62 or death.

(c) Employees Whose Deaths Occur After Becoming Eligible for Coverage But Prior to Attaining Ten Years of Credited Service

(1) If the surviving spouse was married to the deceased employee for at least the one full year immediately preceding the date of death, and the employee dies after becoming eligible for coverage but prior to attaining ten years of credited service, the Corporation will make contributions to continue core coverages for 12 months. Thereafter, the surviving spouse may continue coverages for at least an additional 12 months, on a self-paid basis.

(2) If, as of the employee's date of death, the surviving spouse's age is at least 45 or the surviving spouse's age when added to the employee's years of credited service totals 55 or more, the self-paid coverage may be continued beyond the period specified in subsection (1) above, to the earliest of the surviving spouse's remarriage, attainment of age 62 or death.

(3) In any event, coverages continued under this subsection (c) will cease at the end of the month preceding the month the surviving spouse is eligible for Medicare in the normal course.

(d) Employees Whose Deaths Occur After Attaining Ten or More Years of Credited Service But Prior to Being Eligible to Retire Voluntarily

(1) If an employee dies after becoming eligible for health care coverage and after attaining ten years of credited service but prior to becoming eligible to retire voluntarily under the Corporation's salaried policies and procedures,

and if the surviving spouse is receiving a Part B survivor benefit under the Delphi Retirement Program for Salaried Employees, the Corporation shall make contributions for the surviving spouse to continue core and non-core coverages

(i) until the later of 24 months or the surviving spouse's remarriage, if the deceased employee had continuous service with the Corporation (or an adjusted service date established in accordance with Corporation policy and procedure) commencing prior to January 1, 1993, or

(ii) for 12 months, if the employee had continuous service with the Corporation (or an adjusted service established in accordance with Corporation policy and procedure) on or after January 1, 1993. Following this 12-month period the surviving spouse may continue coverages on a self-paid basis for an additional 12 months and thereafter, until remarriage.

(2) If the deceased employee meets the criteria of this subsection (d) but the surviving spouse is not eligible for a Part B survivor benefit under the referenced Retirement Program, the surviving spouse will be eligible to continue coverages as in subsection (c), above.

(3) In any event, coverages continued under this subsection (d) will cease at the end of the month preceding the month the surviving spouse is eligible for Medicare in the normal course.

(e) Employees Whose Deaths Occur After Becoming Eligible to Retire Voluntarily

(1) If an employee dies after becoming eligible to retire voluntarily under the Corporation's salaried policies and procedures, the Corporation shall make contributions for the surviving spouse to continue core and non-core coverages until the death of the surviving spouse, provided

(i) the employee had continuous service with the Corporation (or an adjusted service date established in accordance with Corporation policy and procedure) commencing prior to January 1, 1988 and has

30 or more years of credited service as of the date of death,

(ii) the employee has at least ten years of credited service and the employee's age when added to the employee's years of credited service as of the date of death total 85 or more, or

(iii) the employee has at least ten years of credited service and is age 60 or older as of the date of death and the surviving spouse is receiving a Part B survivor benefit under the Salaried Retirement Program.

(2) If the employee had continuous service with the Corporation (or an adjusted service date as established in accordance with Corporation policy and procedure) commencing prior to January 1, 1993 but does not meet the criteria of subsections (1)(i), (ii), or (iii) above, the Corporation shall make contributions for the surviving spouse to continue core and non-core coverages for 12 months. Thereafter, the surviving spouse may continue coverage on a self-paid basis.

However, if the employee has at least ten years of credited service and the employee's age when added to the employee's years of credited service as of the date of death does not total 85 or more, and if the surviving spouse is receiving a Part B survivor benefit under the Delphi Retirement Program for Salaried Employees, the Corporation shall make contributions for the surviving spouse to continue core and non-core coverages in accordance with subsection (d) above.

(3) If the employee had such continuous service or an adjusted service date commencing on or after January 1, 1993 the Corporation shall make contributions for the surviving spouse to continue core and non-core coverages for 12 months. Thereafter, the surviving spouse may continue coverage on a self-paid basis.

(4) In any event, coverages continued under this subsection (e) will cease at the end of the month preceding the month the surviving spouse is eligible for Medicare in the normal course.

(5) If the surviving spouse's coverages are continued in accordance with Section 7(e)(1), above, and then cease, in accordance with Section 7(e)(4), above, such surviving spouse will be eligible for a RHRA in the amount of $10,000. Upon the death of the surviving spouse, eligibility for a RHRA is terminated.

(f) Employees Whose Loss of Life Results From Employment With Delphi Corporation

(1) If an employee's loss of life results from accidental bodily injuries caused solely by employment with Delphi Corporation, and results solely from an accident in which the cause and result are unexpected and definite as to time and place, the Corporation will make contributions for the surviving spouse to enroll in and/or continue core and non-core coverages until remarriage.

(2) If such surviving spouse remarries and would have been eligible to continue coverages for a longer period under any subsection above, coverages may be continued in accordance with the appropriate subsection, with coverages and Corporation contributions continued under this subsection counted toward the maximum continuation periods specified in the applicable subsection.

(3) In any event, coverages continued under this subsection (f) will cease at the end of the month preceding the month the surviving spouse is eligible for Medicare in the normal course.

(g) Retirees

(1) If the surviving spouse is eligible only for sponsored dependent coverage as of the retiree's date of death, and is not enrolled as such, no coverage is available. If enrolled as a sponsored dependent, only conversion is available (see Section 9, below).

(2) If the retiree's coverage in retirement is self-paid, and the surviving spouse is enrolled or eligible to be enrolled as a spouse, the surviving spouse may enroll in and/or continue core and non-core coverages on a self-paid basis until death. The election and required payments

must be made in a timely manner [see subsection (a), above].

(3) If the retiree is receiving or entitled to receive Corporation contributions for coverage in retirement and if the surviving spouse is enrolled or eligible to be enrolled as the retiree's spouse as of the date of death, the surviving spouse is eligible for Corporation contributions for core and non-core coverages until death.

(4) In any event, coverages continued under this subsection (g) will cease at the end of the month preceding the month the surviving spouse is eligible for Medicare in the normal course.

(5) If the surviving spouse's coverages are continued in accordance with Section 7(g)(3), above, and then cease, in accordance with Section 7(g)(4), above, such surviving spouse will be eligible for an RHRA as follows:

(i) If the surviving spouse is the surviving spouse of a retiree who had not initiated their RHRA, such surviving spouse is eligible for the full RHRA amount, as described in Section 5, (e)(1)(i), based on the retiree's date of retirement.

(ii) If the surviving spouse is the surviving spouse of a retiree who had initiated their RHRA, such surviving spouse is eligible for the balance remaining in the retiree's RHRA at the time of the retiree's death.

(iii) Upon the death of a surviving spouse who is eligible for an RHRA or has activated an RHRA, eligibility for a RHRA or the activated RHRA is terminated.

Section 8. Dependent Eligibility Provisions

(a) General Provisions

(1) As used in this Section 8, when reference is made to a person (i.e. - person A) being "dependent upon" another person (i.e. - person B), the term shall mean that person B may legally claim, and does claim, an exemption for person A, under Section 151 of the Internal Revenue Code, for Federal income tax purposes.

(2) The provisions of this Section 8 apply with respect to enrollment of certain dependents as secondary enrollees under primary enrollees who elect "self and spouse," "self and child (children)," or "self and family" enrollment, in accordance with Article III, Section 1(a)(1) of the Program and to enrollment of sponsored dependents under subsection (e) below. Unless specifically provided otherwise in the Program, such a dependent has no individual or personal right of enrollment, right to select an option within the Program, or right to continue coverages under the Program.

(3) The Corporation shall have the sole right of determining eligibility of a dependent, consistent with the provisions of this Program.

(4) A primary enrollee claiming initial or continuing eligibility of a dependent shall be responsible for informing the Corporation of any change in status of the dependent which may affect eligibility for coverage under the Program. The primary enrollee shall furnish whatever documentation the Corporation requests or which may be necessary to substantiate the claimed eligibility of a dependent and the social security number of each dependent who is eligible for one. Refusal or failure to furnish such documentation when requested to do so, or to furnish the social security number within a reasonable period of time, shall result in denial or withdrawal of eligibility for such dependent.

(5) Unless otherwise provided, coverage may be reinstated for a dependent who loses eligibility in accordance with the provisions of this Program, and who once again meets the requirements for dependent eligibility.

The effective date of coverage will be the first day of the month following the month in which a valid enrollment form and any necessary or requested supporting documentation is received by the Corporation. For purposes of establishing an effective date under this provision only, if the request for reinstatement of coverage is based on "full-time" student status as provided in Art. III, 8(c)(1)(ii), proof of enrollment as a full-time student for one school term will be accepted

subject to subsequent submission of proof that such school term was completed.

(6) When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, the retroactivity will not exceed 12 months from the month in which the error or omission is discovered, unless the error or omission is on the part of the Corporation.

This retroactive enrollment provision shall not apply to surviving spouses who are not entitled to Corporation contributions for coverage. Such surviving spouses electing to continue coverages on a self-paid basis must make such election as stipulated in Article III, Section 7(a). This retroactive enrollment provision also shall not apply to sponsored dependents, as discussed in subsection (e) below.

(7) The receipt of a benefit under the Delphi Retirement Program for Salaried Employees as an "alternate payee" in accordance with the Retirement Equity Act of 1984 shall not serve to entitle such recipient to coverages or continuation of coverages under this Program.

(8) Any dependent, including a spouse, acquired by a retiree after retirement, will be limited to coverage as a sponsored dependent as set forth in subsection (e) below. A dependent is not "acquired" after retirement if the dependent's relationship with the primary enrollee was established prior to the primary enrollee's retirement and has existed continuously thereafter. A child born after the primary enrollee's retirement will be limited to coverage as a sponsored dependent, unless such child was conceived prior to retirement.

(9) Provisions will be made for the enrollment and administration of coverage for an individual determined to qualify for coverage pursuant to a Qualified Medical Child Support Order (QMCSO) under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

(b) Spouse

(1) The spouse of an eligible and enrolled employee or retiree shall be eligible for coverage except as stated in subsection (a)(8) above. A surviving spouse of an employee or retiree, as defined in Section 7 above, may not have or add a new spouse as a dependent.

(2) A spouse by common-law marriage shall be eligible for coverage only to the extent such relationship is recognized by the laws of the state in which the employee or retiree is enrolled, and the employee or retiree has met such requirements for documentation of the status as may be necessary by law and required by the Corporation.

(3) The effective date of coverage for a spouse shall be the later of the effective date of coverage for the employee or retiree, or the date of marriage. For a common-law spouse, the effective date of coverage shall be the date of receipt by the Corporation of a completed enrollment form and any necessary or requested supporting documentation.

(4) A spouse's eligibility for coverage shall cease on the earlier of:

(i) the date the primary enrollee's coverage ceases, except that, in the case of the primary enrollee's death, coverage shall cease on the last day of the month in which the primary enrollee dies, unless the spouse is eligible for coverage as a surviving spouse as set forth in Section 7 of this Article, or

(ii) the date of the final decree of divorce.

(c) Children

(1) Children of a primary enrollee, or of the spouse of an eligible and enrolled employee or retiree, shall be eligible for coverage if, as to each child, all of the following criteria are met.

(i) Relationship. The child must be the child of the primary enrollee, or of an employee's or retiree's spouse, by birth or legal adoption.

This requirement will be deemed to have been met for a child who was properly enrolled under the then applicable General Motors Salaried Health Care Program's "guardianship" or "principally supported child" provisions as of October 31, 1992, who has continued to be the primary enrollee's dependent since that time, and who has been continuously enrolled and has continuously satisfied the other eligibility criteria for children.

A child in the process of being adopted by a primary enrollee will be deemed to satisfy the relationship test when the primary enrollee takes physical custody of the child pursuant to the adoption procedure and the child resides with the primary enrollee, or on an earlier date if required under OBRA '93.

(ii) Age. The child must not have reached the end of the calendar year in which the child becomes age 19, unless such child has been determined to be totally and permanently disabled or is a full-time student, as indicated below.

For the purposes of this subsection, "totally and permanently disabled" means having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death or be of long-continued or indefinite duration.

In case of dispute over the nature of the condition, the Corporation's Medical Director's decision shall be final.

This total and permanent disability feature is a continuation provision. It does not apply to a child who is ineligible for coverage before the end of the calendar year in which age 25 is attained (e.g., the primary enrollee is not yet eligible for coverage). It does not apply to a child who first becomes totally and permanently disabled after the end of the year in which age 25 is attained. It does not apply to an individual who was eligible for coverage

as a totally and permanently disabled child, who loses such eligibility (e.g., by marriage, by failing to satisfy the residency requirement or by failing to meet the definition of totally and permanently disabled) and, after the end of the calendar year in which age 25 is attained, again satisfies the criteria (e.g., divorces, returns home, or has a relapse or new disability).

A child who has reached the end of the calendar year in which such child turns age 19, has not reached the end of the calendar year in which such child turns age 25 and has not been identified as totally and permanently disabled, will satisfy this age requirement only if such child is a full-time student for at least one school term during the calendar year. Coverage may be continued while the child continues to maintain such student status, but in no event beyond the end of the calendar year in which such child turns age 25.

For an otherwise eligible full-time student age 24 or older who has not reached the end of the calendar year in which such student turns 25, the child must be dependent upon the primary enrollee, or upon the spouse of an eligible and enrolled employee or retiree, as defined under Section 152 of the Internal Revenue Code, for federal income tax purpose. This dependency requirement shall be waived with respect to a child (by birth or legal adoption) of a divorced employee or retiree until the end of the calendar year in which such child turns age 25, if the divorce decree, or order of the court of proper jurisdiction, or amendment of such decree or order, stipulates that such employee or retiree is legally responsible for providing health care coverage for such child.

(iii) Marital Status. The child must be unmarried.

(iv) Residency. The child must reside with the primary enrollee, as a member of such enrollee's household. A child temporarily away from home while attending school will

be deemed to meet this residency requirement.

The residency requirement also will be deemed to be met if the child is not a member of the primary enrollee's household, but the primary enrollee is legally responsible, pursuant to a court order, for the provision of health care for the child. However, if the legal responsibility is established pursuant to a paternity order or any other order which does not meet the requirements for a QMCSO under OBRA '93, the non-resident child must meet the dependency definition in subsection (a)(1), above.

(2) An eligible surviving spouse may not enroll a child unless the child was eligible to be enrolled prior to the death of the employee or retiree or, in the case of a child born after the death of the employee or retiree, unless such child is the issue of the surviving spouse's marriage to the deceased employee or retiree, and was conceived prior to such employee's or retiree's death.

(3) The effective date of coverage for a child shall be the later of the effective date of coverage for the primary enrollee, or in the case of:

(i) A birth - the date of birth;

(ii) A legal adoption - the date the adoptive parent(s) takes physical custody of the child pursuant to the adoption process, or an earlier date if required under OBRA '93; and

(iii) A stepchild - the date the child becomes a member of the employee's or retiree's household.

(4) A child, as defined above, shall cease to be eligible for coverage as of:

(i) the date of marriage of such child;

(ii) the last day of the month in which the child ceases to meet the residency criteria of subsection (c)(1)(iv) above;

(iii) the last day of the calendar year in which the child becomes age 19, except in the following cases:

Totally and Permanently Disabled Children - coverage may be provided/continued for calendar years beyond age 19 for a child who is totally and permanently disabled, as defined under subsection 8(c)(1)(ii) above; however, eligibility shall cease as of the last day of the month in which the child ceases to meet such definition or fails to satisfy other criteria for continuing coverage (e.g.- the child marries);

Full-time Students Who Have Not Reached the End of the Calendar Year in Which They Turn Age 25 - coverage may be provided/continued for calendar years beyond age 19 (but not beyond the end of the calendar year in which age 25 is attained) for a child who is a full-time student; however, eligibility shall cease as of the last day of the month in which the primary enrollee reasonably should know the child will not maintain such status for at least one school term during the calendar year;

(iv) the date the primary enrollee's coverage ceases, except that, in the case of the primary enrollee's death, coverage for such child shall cease on the last day of the month in which the primary enrollee dies, unless such child is eligible for coverage as a dependent child of the surviving spouse of such employee or retiree; or

(v) the last day of the month in which the child ceases to be dependent upon the primary enrollee, for children whose eligibility is being continued under the "guardianship" or "principally supported child" provisions of a prior Program.

(d) Same-Sex Domestic Partners and Their Children

(1) Effective January 1, 2001, the eligible domestic partner of an employee may be enrolled for coverage. To qualify for enrollment, the employee and domestic partner must:

(i) Be the same sex;

(ii) Have shared a continuous committed, relationship for at least six months, intend to do so indefinitely and have no such domestic partner relationship with any other person;

(iii) Reside in the same household;

(iv) Share responsibility for each other's welfare and financial obligations;

(v) Not be related by blood to a degree of kinship that would prevent marriage from being recognized under law;

(vi) Be over the age of 18, of legal age and legally competent to enter into a contract;

(vii) Reside in a state where marriage between two persons of the same sex is not recognized as valid under law;

(viii) Not be married to any other person

(2) If the enrollee resides in a state that has formal recognition of domestic partner relationship, such recognition is required for enrollment of the domestic partner.

(3) The employee and the domestic partner will be required to complete an affidavit attesting to meeting the eligibility requirements and provide any additional documentation necessary to support the claimed eligibility.

(4) An eligible domestic partner's child may be enrolled if the child is dependent upon the primary enrollee as defined in subsection (a)(1) above and the child meets all of the Program's eligibility provisions pertaining to children.

(5) Neither a domestic partner nor his or her children are eligible to be enrolled following the primary enrollee's retirement. However, coverage for an eligible domestic partner, or his or her child, enrolled prior to the primary enrollee's retirement may be continued in retirement. Under no circumstances will the continuation privileges afforded a domestic

partner exceed those of a similarly situated spouse.

(6) If the primary enrollee and his or her domestic partner terminate the relationship, an opportunity will be provided to continue coverage on a basis comparable to that provided under applicable Federal laws (see Section 10 below).

(7) In the event of the primary enrollee's death, a surviving domestic partner will be provided continuation opportunities comparable to a similarly situated surviving spouse. Under no circumstances will the continuation privileges afforded a domestic partner exceed those of a similarly situated spouse.

(e) Sponsored Dependents

Any dependent, including a spouse, acquired by a retiree after retirement, will be limited to coverage as a sponsored dependent. A dependent is not "acquired" after retirement if the dependent's legal relationship with the primary enrollee was established prior to the primary enrollee's retirement and has existed continuously thereafter.

(1) A primary enrollee (other than one classified as a Cooperative Student) may obtain core coverages (other than Extended Care Coverage) for certain dependents other than those specified in subsections (b) and (c) above. Such dependents shall be limited to:

(i) unmarried children of the primary enrollee or the primary enrollee's spouse who reside with the primary enrollee but who are ineligible for coverage as dependent children due to age,

(ii) unmarried children residing with the primary enrollee and who are the children of individuals who themselves are eligible and enrolled for coverage as dependent children of the primary enrollee,

(iii) unmarried children whose parents are both deceased, who reside with the primary enrollee and for whom the primary enrollee and/or the primary enrollee's spouse is the legal guardian pursuant to a court order,

(iv) dependent parents of the primary enrollee or primary enrollee's spouse, and

(v) a spouse or children acquired after retirement as set forth in subsection (a)(8) above.

Before becoming eligible for coverage, sponsored dependents who are not citizens of the United States must reside in the United States for one full year, and must be legally entitled to remain in the United States indefinitely. Sponsored dependents must be dependent upon the primary enrollee as defined in subsection (a)(1) above. They must be designated as sponsored dependents on a valid enrollment form signed by the primary enrollee. The coverages shall be provided under the Program option elected by the primary enrollee.

(2) Coverages provided under this subsection for a sponsored dependent enrolled at the time of an employee's or retiree's death may be continued at the option of the employee's or retiree's surviving spouse while such surviving spouse is eligible to continue, and is enrolled for, coverages as provided in Section 7 of this Article. A surviving spouse may not add any new sponsored dependents or add a previously enrolled sponsored dependent who was removed from coverage.

(3) The primary enrollee shall pay the full cost of coverages under this subsection, and the Corporation shall not contribute toward the cost of health care coverages for any sponsored dependents.

(4) The effective date of coverages for an eligible sponsored dependent shall be the later of the effective date of coverages for the primary enrollee, or the first day of the month following the month of receipt by the Corporation of a completed enrollment form and any supporting documentation as may be required by the Corporation. However, the effective date for a sponsored dependent previously enrolled as such, and whose coverages as a sponsored dependent were discontinued, shall be the first day of the sixth month following the month in which the application for reinstatement is received.

(5) Each sponsored dependent enrolled under an option that requires deductibles or copayments shall be subject to separate deductibles and copayments as specified in Article II, Section 4.

(6) Coverage for a sponsored dependent shall cease on the earliest of:

(i) the last day of the month in which the person ceases to meet the eligibility criteria set forth in subsection (e)(1) above,

(ii) the last day of the month preceding the month for which the required contribution was due but not paid, and

(iii) the date the primary enrollee's coverages cease except that in the case of the primary enrollee's death, coverage for such sponsored dependent shall cease on the last day of the month in which the primary enrollee dies, unless the sponsored dependent has coverages continued in accordance with subsection (e)(2) above.

(f) Cessation of Coverages for Dependents of Retirees who attain Medicare Eligibility in the Normal Course

The foregoing to the contrary notwithstanding, cessation of coverages for secondary enrollees of a retiree whose coverages ceased solely as a result of the retiree attaining Medicare eligibility in the normal course shall be as follows:

(1) A spouse's coverages will cease on the earlier of:

(i) the first day of the month during which the spouse attains Medicare eligibility in the normal course, or
(ii) the final date of the divorce decree.

(2) A child's coverage will cease on the earlier of:

(i) the first day of the month during which the child attains Medicare eligibility in the normal course, or
(ii) the dates specified in Section 8,(c)(4)(i), (ii), (iii) or (v), above.

(3) Cessation of coverages for a same-sex domestic partner and their children will be on the same basis as those of a similarly situated spouse or similarly situated children.

Section 9. Conversion Privilege

(a) Any former enrollee who is no longer eligible to continue coverages under the Program may be offered an opportunity to obtain other available coverage, on a self-paid basis, from the carrier with which enrolled at the time eligibility terminated. Such conversion privilege shall not apply to prescription drug, hearing aid, vision, dental, or Extended Care Coverages.

(b) A former enrollee wishing to exercise this privilege shall make application to the carrier within 30 days of termination of eligibility under this Program.

Section 10. Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, was implemented January 1, 1987 for salaried enrollees. COBRA provides continuation rights to certain employees or dependents who would ordinarily lose eligibility for coverage under this Program.

(a) For purposes of COBRA, this Program is considered to be a single plan offering core coverages and non-core coverages, regardless of the coverage option available to and/or chosen by the primary enrollee, and regardless of the entity chosen by the Corporation to administer such coverages on the Corporation's behalf.

(b) The Corporation is responsible for providing notifications, as required under COBRA, to "qualified beneficiaries," as defined therein. The Corporation may delegate the administrative functions associated with COBRA. A qualified beneficiary is responsible for providing notice to the Corporation within 60 days of

(1) divorce or legal separation,

(2) the date an enrolled dependent ceases to qualify as a "dependent child" as defined under Article III, Section 8(c) of this Program,

(3) a Social Security Act determination of Title II or XVI disability within 60 days of the qualifying event, or

(4) within 30 days of a Social Security Administration determination that a qualified beneficiary is no longer disabled.

Failure to comply with the above notification requirement will result in the loss of eligibility for the affected individual(s) under COBRA.

(c) COBRA continuation coverage is available to employees whose employment is terminated for any reason other than gross misconduct. Any employee separated as a discharge will be considered to have been terminated for gross misconduct.

(d) The COBRA continuation privileges are available for up to 18 months if coverage is lost due to:

(1) termination of employment (voluntarily or involuntarily) unless termination is due to gross misconduct, or

(2) reduction of hours (including leave of absence).

(e) In the event a qualified beneficiary is determined by the Social Security Administration to be disabled within 60 days of the termination or reduction in hours under Title II or XVI of the Social Security Act, the COBRA continuation privileges are available for up to 29 months if coverage is lost due to:

(1) termination of employment (voluntary or involuntary) unless termination is due to gross misconduct, or

(2) reduction of hours (including leave of absence).

(f) COBRA continuation is available for up to 36 months to:

(1) spouses who lose coverage because of the employee's or retiree's death or because of divorce from the employee/retiree, and

(2) dependent children who become ineligible under Article III, Section 8(c) of the Program.

(g) COBRA continuation is not available to sponsored dependents, (except spouses or children acquired after

retirement as referenced in Article III, 8 (e), nor to individuals after they become covered under another employer sponsored group health plan, if such coverage commences after they have elected COBRA coverage (unless, after December 31, 1989, the other employer sponsored group health plan precludes coverage for a pre-existing condition of the qualified beneficiary). Similarly, COBRA continuation is no longer available to individuals when they become enrolled in Medicare under Title XVIII of the Social Security Act after they have elected COBRA coverage. In either case, when COBRA coverage is not elected until after coverage under the group plan or Medicare commences, then COBRA coverage continues subject to all other Program provisions.

(h) The option to elect continued coverage under this Program through COBRA provisions requires the enrollee to self-pay at 102% (150% in certain cases) of the full cost of elected coverage.

(i) To the extent the Corporation makes alternative continuation privileges ("Program Continuation") available that do not satisfy all the requirements for COBRA continuation coverage, enrollees shall have the opportunity to elect either COBRA continuation coverage or Program Continuation. An election of COBRA continuation coverage automatically will terminate the enrollee's eligibility for Program Continuation.

(j) To the extent the Corporation makes Program continuation privileges available that do satisfy all of the requirements for COBRA continuation coverage, such Program Continuation will be integrated with the COBRA continuation coverage.

(k) In the event a primary enrollee is entitled to elect between COBRA continuation coverage and Program Continuation, coverage will be continued beyond the point coverage as an active employee or dependent of an active employee ceases as if the primary enrollee elected Program Continuation, subject to the enrollee’s fulfillment of all requirements of such continuation.

If the primary enrollee subsequently elects COBRA continuation during the election period described in subsection (m) below, and pays any required contribution, coverages will be adjusted retroactively to provide the COBRA continuation.

(l) Unless advised otherwise by a COBRA qualified beneficiary, an election of Program Continuation by the primary enrollee shall be presumed to be an election for all other enrollees and/or qualified beneficiaries covered under such primary enrollee's coverage.

(m) The election period for COBRA continuation begins on the date on which coverage would terminate due to a qualifying event and must be 60 days in length. However, the election period ends the later of 60 days from the qualifying event or 60 days from the actual notice to the qualified beneficiary. Nothing in this provision relieves a qualified beneficiary from the obligations or implications of subsection (b) above.

(n) In all cases, COBRA continuation coverage commences on the first day of the month following the month in which the qualifying event occurred.

(o) COBRA continuation ceases on the earliest of:

(1) 18 months from the date COBRA continuation coverage commences for employees whose employment has been terminated or reduced in hours; however, this may be extended up to 29 months (i.e., for an additional 11 months) for a qualified beneficiary who has been determined by the Social Security Administration to be disabled with a Title II or XVI disability at the time of the qualifying event and who remains disabled;

(2) 36 months from the date COBRA continuation coverage commences for any other qualifying event;

(3) the first of the month for any month in which a required contribution is due but not paid;

(4) the date a qualified beneficiary becomes covered under another employer-based health care plan (for qualifying events before January 1, 1990);

(5) the date a qualified beneficiary is covered under another employer-based health care plan (for qualifying events after December 31, 1989) which does not preclude coverage for a pre-existing condition of the qualified beneficiary;

(6) the date a qualified beneficiary becomes eligible for Medicare; and

(7) the date coverage is terminated for all employees.

(p) Conversion contracts, as described in Section 9, above, are available to COBRA continuation coverage enrollees at the time their continuation period is exhausted.

ARTICLE IV

DEFINITIONS

Unless otherwise indicated, as used in this Program:

1. "active service" or in "active service" - means at work and receiving compensation for periods of work scheduled by the Corporation, or otherwise scheduled to work but absent due to,

   (a) attendance at school as a Delphi Fellow, Deferred Employment Graduate Study Fellow, or as a Delphi sponsored cooperative student,

   (b) vacation time authorized in advance,

   (c) a specified holiday,

   (d) "compensable disability" leave of absence,

   (e) short-term casual absence, whether scheduled or unscheduled, under circumstances where the employee is entitled to receive full or partial compensation,

   (f) bereavement, jury duty, or short-term military leave of absence under circumstances where the absence is authorized in advance and the employee is entitled to receive full or partial compensation from the Corporation for the day(s) of absence, or

   (g) effective January 1, 2002, any disability leave of absence.

   An employee is not in active service if the employee is absent every scheduled work day during a month, for reasons other than those specified above, whether or not such absence is excused, if the employee is not entitled to receive compensation for such absent time.

   An employee is not in active service in any full month in which such employee is not scheduled to work due to any leave of absence (other than short-term military leave referred to in subsection (f) above), regardless of whether the employee may be entitled to some compensation for any day(s) during such month.

2. "Authorized Employee"- means a Delphi employee whose duties require access to PHI for purposes of administering the Program, including: the Privacy Official/Director, Health Care; Manager, Health Care; Analyst, Health Care; Coordinator, Health Care; Staff Assistant, Health Care; Executive Director, Employee Benefits; Administrative Assistant, Employee Benefits; members of the Delphi Employee Benefit Plans Committee ("EBPC"); personnel specifically designated as an Authorized Employee by the Privacy Official or his delegate (e.g., finance staff personnel, audit staff personnel); and in-house counsel to Employee Benefits.

3. "benefit" - means a payment made, in accordance with the Program provisions, to an enrollee, or to a provider on behalf of an enrollee.

4. "carrier" - means any entity by which Program coverages are administered or benefits are paid. The term includes, but is not limited to, the following types of entities:

   (a) an insurance company,

   (b) a Blue Cross or Blue Shield Plan,

   (c) a dental plan,

   (d) a group practice plan or health maintenance organization,

   (e) a preferred provider organization,

   (f) Delphi Corporation,

   (g) a non-governmental administrative services organization.

5. "cost of coverages" means the Corporation's reasonable estimate of the monthly amount required to provide coverages for an individual or group of individuals, established on an actuarial basis taking into account such factors as enrollment classification [self only, self and spouse, self and child (children), self and family, spouse only, spouse and child (children), child (children)], health care option (BMP, EMP, CHSP, POS, or HMO), scope of coverages (what services are covered), regional cost differences and administrative costs. It includes both the Corporation contribution and any primary enrollee contribution(s), as required under the Program. The cost is accrued and reported on

a monthly basis. In the case of coverages delivered through certain pre-payment agencies, such as a health maintenance organization or an alternative dental plan, it means the total monthly premium required to provide such coverages.

6. "coverage" means a specified set of health care services or expenses (i.e., "covered services or expenses") which may be incurred by an enrollee, and for which benefits may be paid under the Program provisions. The categories of coverage include "core" coverages (hospital, surgical, medical, hearing aid, prescription drug, mental health and substance abuse, and Extended Care Coverage) and "non-core" coverages (dental and vision).

   Not every health care expense incurred by an enrollee falls within the Program coverages.

7. "covered service" means a service that is included within the range of services identified in the Program, and that meets all Program requirements to be eligible for payment of benefits. A service within the range of those identified in the Program (e.g., a diagnostic radiology service) but which does not meet all of the specifications to be eligible for benefit payment (e.g., if it is an experimental service or if it is not medically necessary) is considered a non-covered service.

8. "effective date" means the date on which a given coverage begins for an enrollee, as determined by the Corporation, consistent with the Program provisions.

9. "electronic protected health information" or "ePHI" means electronic Protected Health Information that is created, received, maintained or transmitted by electronic media by or on behalf of the Program.

10. "employee" -

   (a) means certain persons employed in the United States by the Corporation or by a wholly-owned or substantially wholly-owned domestic subsidiary thereof, under policies established by the Corporation and set forth in administrative manuals addressing such policies, on a salaried or other basis, herein referred to as "salaried employees", includes:

      (1) "Salaried full time employee";

(2) "flexible service" [see Article II, 4(h)(2) for a description of coverages];

(3) "Delphi Fellows";

(4) "Cooperative Students" - hired prior to January 1, 1999[see Article II, 4(h)(3) for a description of coverages];

(5) "U.S. Expatriates" - [see Article II, 4(h)(1) for a description of coverages]; and

(6) certain other foreign nationals who are deemed by the Corporation to be employees eligible for benefits under the Program [see Article II, 4(h)(1)for a description of coverages].

(b) The term "employee" shall not include:

(1) employees represented by a labor organization which has not signed an agreement making the Program applicable to such employees;

(2) employees of any directly or indirectly wholly-owned or substantially wholly-owned subsidiary of the Corporation unless specifically included by the Delphi Corporation Board of Directors (for example, the Board of Directors has specifically approved the inclusion of Delco Electronics Corporation);

(3) "leased employees" as defined under Section 414(n) of the Internal Revenue Code;

(4) individuals employed on a "temporary", "part-time", or "per diem" basis;

(5) individuals hired as a high school cooperative student, university intern, or university cooperative student hired on or after January 1, 1999;

(6) non-employee members of the board of directors; or

(7) contract employees, bundled-services employees, consultants, individuals who

have represented themselves to be independent contractors, persons who the Corporation does not consider to be employees, or similarly situated individuals regardless of whether the individual is a common law employee of the Corporation. The purpose of this provision is to exclude for participation in the Program all persons who may actually be common law employees of the Corporation, but who are not paid as though they were employees of the Corporation regardless of whether that exclusion is correct.

(c) To the extent a labor organization has signed an agreement with the Corporation, and under such agreement certain employees represented by such labor organization are excluded from the Program in whole or in part, such represented employees shall be regarded as employees for the purposes of this Program only to the extent required to comply with such agreement.

11. "employer" means Delphi Corporation.

12. "enrollee" means a person who is eligible for coverages under the Program and who is enrolled for such coverages. Depending upon the context, an enrollee may be a "primary enrollee" or a "secondary enrollee." The determination of eligibility in a manner consistent with the Program provisions is the responsibility of the employer.

"primary enrollee" means an employee, retiree or surviving spouse eligible in such individual's own right.

"secondary enrollee" means a spouse, child or sponsored dependent entitled to coverage by virtue of the individual's relationship to a primary enrollee.

13. "Medicare" means the Federal program established by Title XVIII of Public Law 89-97, as amended, which provides health insurance for the aged and disabled. It includes Part A (Hospital Insurance Benefit for the Aged and Disabled), Part B (Supplementary Medical Insurance Benefit for the Aged and Disabled) and, effective January 1, 2006, Part D (Prescription Drug Benefits).

14. "Plan" means a particular coverage or group of coverages under the Program; the "Medical Plan" is comprised of that portion of the Program providing Appendix A (hospital, surgical, medical, prescription drug, hearing aid, etc.) and Appendix B (mental health and substance abuse) coverages; the "Dental Plan" is that portion of the Program providing Appendix C coverage; and the "Vision Plan" is that portion of the Program providing Appendix D coverage.

15. "Plan Sponsor" – means Delphi Corporation in its capacity of sponsoring the Program by engaging in activities including, but not limited to, establishment, maintenance, modification, and funding of the Program.

16. "Protected Health Information" – as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), means information created or received by a health plan, health care provider, or health care clearinghouse that relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual. In addition, the information either identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual. References to PHI are to be read to refer to "ePHI" where appropriate in context.

17. "provider" means a physician, hospital, or other approved facility, agency or individual who is qualified to render service(s) or furnish materials under this Program.

18. "reasonable and customary charge" as it relates to covered expenses, unless otherwise specified, means the actual amount a provider charges for such services rendered or materials furnished, but only to the extent that the amount is reasonable, as determined by the carrier, taking into consideration, among other factors, the following:

    1. the usual amount which the individual provider most frequently charges the majority of patients or customers for a similar service rendered or materials furnished;

    2. the prevailing range of charges made in the same geographic area by providers with similar

training and experience for the service rendered or materials furnished; and

3. unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular service rendered or materials furnished.

The carrier is responsible for determining the appropriate reasonable and customary charge for a given provider, service or material. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The determination by the carrier as to the reasonable and customary charge shall be final and conclusive, and shall be given full force and effect unless it is determined by the Program Administrator to have been contrary to the Program provisions or it is proven that the determination was arbitrary and capricious.

As used in this Program, reasonable and customary also refers to the forms and/or amount of payment used by carriers and preferred provider or similar organizations to reimburse participating or contracted providers for covered services.

19. "service" or "length of service" - means that period of employment with the Delphi Corporation and General Motors Corporation which commences with the service date and is considered unbroken by the Corporation as determined by its salaried personnel policies and procedures. Service date shall include an adjusted service date determined in accordance with the Corporation's salaried policies and procedures.

20. "Summary Health Information" – means information that may be individually identifiable health information, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and which has been de-identified, except that the geographic information need only be aggregated to the level of a five-digit zip code, if such aggregation does not identify an individual.

ARTICLE V

SPECIAL BENEFIT

Section 1. Eligibility for the Special Benefit

(a) In order to be eligible for a Special Benefit under this Article V, an individual must be eligible for Corporation contributions for health care (in accordance with Article III, 5(d) of the Program) and must be:

(1) an employee eligible for Extended Disability Benefits under the Delphi Life and Disability Benefits Program for Salaried Employees, or

(2) a retired employee (other than a deferred vested retiree) who retired on or after October 1, 1979, or

(3) a surviving spouse (but not the surviving spouse of a former employee eligible for a deferred retirement benefit, or a surviving spouse or surviving divorced spouse eligible for a pre-retirement survivor benefit under Part A, Article I, Section 5(j) of the Delphi Retirement Program for Salaried Employees);

and must be:

(4) age 65 or older, or

(5) if under age 65, enrolled in Medicare Part B;

(6) receiving a monthly retirement benefit under Article 1 of Part A of the Delphi Retirement Program for Salaried Employees, or

(7) receiving a monthly Extended Disability Benefit under the Delphi Life and Disability Benefits Program for Salaried Employees (or eligible for such a benefit but not receiving it due to reductions under that Program).

(b) Neither an employee who retires from the status of a Flexible Service Employee, a Cooperative Student or an Expatriate employee, nor such a person's surviving spouse, is eligible for a Special Benefit.

Section 2. Amount of the Special Benefit

(a) Subject to subsections 2(b) and (c), below, an individual identified in subsection 1(a) above, shall be eligible to receive a monthly Special Benefit equal to the lesser of the generally applicable Medicare Part B premium in effect as of January 1 of the calendar year, or $76.20. Such amount may be adjusted by the Corporation from time to time.

(b) Retirees and surviving spouses eligible for Medicare Part B coverage must be enrolled in Medicare Part B as a condition for receipt of the Special Benefit.

(c) Any recipient who is enrolled in Medicare Part B coverage and discontinues such coverage will have the Special Benefit discontinued for periods during which Medicare Part B enrollment is not maintained.

Section 3. Payment of the Special Benefit

(a) Payment shall commence on the earlier of:

(1) the first day of the month following the month during which age 65 is attained, [subject to the provision set forth in subsection 2(b) above], or

(2) the first day of the month in which an otherwise eligible individual under age 65 becomes enrolled for Medicare Part B.

Individuals under age 65 must make application to the Corporation on a form provided for this purpose.

(b) Payment of the Special Benefit will be made concurrent with a monthly retirement or Extended Disability Benefit payment and for the same period. In the event an eligible employee receives no monthly Extended Disability Benefit payment because of reductions under the Delphi Life and Disability Benefits Program for Salaried Employees, a Special Benefit will be paid for that month.

(c) Not more than one Special Benefit payment shall be made to any individual for any one month under this Program.

(d) No Special Benefit payment shall be made to any individual under age 65 for any month in which such

individual is not enrolled for Medicare Part B coverage.

(e) In the event the individual does not inform the Corporation of Medicare enrollment in a timely manner, retroactive payment of the Special Benefit will be limited to 12 months.

APPENDIX A

HOSPITAL, SURGICAL, MEDICAL,
PRESCRIPTION DRUG AND HEARING AID COVERAGES

I. Definitions

As used herein:

A. "accidental injury" means a bodily injury such as a strain, sprain, abrasion, contusion or other condition which occurs as the result of a traumatic incident such as, but not limited to: ingestion of poison; overdose of medication, whether accidental or intentional; allergic reaction resulting from trauma, such as bee stings or insect bites; inhalation of smoke, carbon monoxide, or fumes; burns, frostbite, sunburn, and sunstroke; and attempted suicide.

B. "ambulance services" means medically necessary transportation and life support services furnished within the Program provisions to sick, injured or incapacitated patients by a licensed ambulance provider meeting Program standards, utilizing ambulance vehicles and personnel recognized as qualified to perform such services at the time and place where rendered.

C. "approved" - see "participating"

D. "benefit period" means a period of time during which an enrollee is entitled to receive certain covered services which are subject to Program maximums (see App. A, II.B. and App. B, II.B.). The services which may be subject to maximums include, but are not limited to, inpatient hospital services (with special provisions for pulmonary tuberculosis treatment under this Appendix, and mental health and substance abuse treatment under Appendix B), admissions to skilled nursing facilities (whether under this Appendix or Appendix B), treatment under psychiatric partial hospitalization programs (and substance abuse partial hospitalization programs), substance abuse halfway house programs (under Appendix B) and hospice care.

E. "covered expenses" means the reasonable and customary, preestablished, or contracted charges incurred for covered materials and services, as described in Section III of this Appendix, provided or rendered to or for an enrollee for treatment of illness or injury, and performed by a provider or prescribed by a physician in accordance with the provisions of this Program. Such

covered expenses fall in the following areas of coverage or categories of expenses:

1. hospital expenses;

2. skilled nursing facility expenses;

3. physical, speech and functional occupational therapy and cardiac rehabilitation expenses;

4. home health care expenses;

5. medical, surgical expenses;

6. ambulance service expenses;

7. prescription drug expenses;

8. hearing aid expenses;

9. durable medical equipment and prosthetic or orthotic appliance expenses; and

10. hospice expenses.

F. "custodial" or "domiciliary" care or services means the type of care or service which, even if ordered by a physician, is primarily for the purpose of meeting personal needs of the patient or maintaining a level of function (as opposed to specific medical, surgical or psychiatric care or services designed to reduce the disability to the extent necessary to enable the patient to live without such care or services). Custodial or domiciliary care generally does not require the continuing attention of medically skilled personnel, and usually can be provided by aides or other persons withlimited training, operating without direct medical supervision. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, toiletting, meal preparation and eating, taking of medications, ostomy care, bed baths, hygiene or incontinence care, checking of routine vital signs, routine dressing changes and routine skin care. The determination as to the nature of the care is not a function of the setting (e.g., hospital, skilled nursing facility, nursing home, another institutional setting or the patient's home) or of the professional status of the person (e.g., physician, nurse, therapist or aide) rendering the service, but of the severity of the patient's illness and the intensity of services being performed. The carriers or Utilization Review Organization, as appropriate shall have discretionary authority to interpret, apply and construe this

provision of the Program. The carrier's (or Utilization Review Organization's) determination as to the nature of the care being provided shall be given full force and effect unless it is determined by the Plan Administrator that the determination was inconsistent with the Program provisions or arbitrary and capricious.

G. "domiciliary" - see "custodial"

H. "drugs, biologicals, and solutions" means medicinal agents which are approved for commercial distribution by the Federal Food and Drug Administration and are legally prescribed for the treatment of an illness or injury.

I. "durable medical equipment" means equipment which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to an enrollee in the absence of illness or injury.

J. "freestanding outpatient physical therapy facility" means a facility, separate from a hospital, which provides outpatient physical therapy services. Such facilities must meet Program standards and be approved by the local carrier.

K. "functional occupational therapy" - see "physical therapy"

L. "home health care" means care or services provided in the home for a patient whose condition does not warrant care in an institutional setting (such as a hospital or skilled nursing facility). The care/services may be skilled or unskilled in nature.

M. "home health care agency" means a centrally administered agency providing physician-directed nursing and other paramedical services to patients at home. A home health care agency must meet Program standards and be approved by the local carrier.

N. "hospice" means a program of medical and non-medical services provided for terminally ill enrollees and their families through agencies which administer and coordinate the services. A hospice program must meet Program standards and be approved by the local carrier.

O. "hospital" means a facility which provides diagnostic and therapeutic services on a continuous inpatient basis for the surgical, medical, or psychiatric diagnosis, treatment, and care of injured or acutely sick persons.

These services are provided by, or under the supervision of, a professional staff of licensed physicians and surgeons. A hospital continuously provides 24 hours-a-day nursing service by registered nurses. A rehabilitation institution shall be considered to be a hospital if the institution is approved as such under this Program. A hospital must meet all applicable local and state licensure and certification requirements and be accredited as a hospital by state or national medical or hospital authorities or associations.

A hospital is not, other than incidentally, a place for custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care; an institution for exceptional children; an institution to which enrollees may be remanded by the judicial system; an institution for the treatment of the aged or substance abusers; or a skilled nursing facility or other nursing care facility. It does not include a health resort, rest home, nursing home, convalescent home, or similar institution.

P. "medical appropriateness" means that the medically necessary service, care, treatment or supply is the type, level and setting considered the most appropriate based on accepted standards of practice in the United States for the patient's condition.

Q. "medical emergency" means a permanent health threatening or disabling condition, other than an accidental injury, which requires immediate medical attention and treatment.

The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the enrollee's health, or place such enrollee's life in jeopardy. The enrollee's signs and symptoms verified by the treating physician at the time of treatment, and not the final diagnosis, must confirm the existence of a threat to the enrollee's life or bodily functions. The carriers shall have authority to construe, interpret and apply this provision of the Program. The carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to be inconsistent with the Program provisions or arbitrary and capricious.

R. "medical necessity" means that the need is present for the services, care, treatment or supplies based on accepted standards of medical practice in the United States for the treatment of any injury, illness or pregnancy. Determinations of the Control Plan or

Utilization Review Organization, as appropriate, as to medical necessity and the accepted standards of medical practice are based on factors which include, but are not limited to: scientific data (such as reported controlled studies), information from local and national medical, professional and insurance societies, organizations, committees and bodies; and approvals and policies of the Food and Drug Administration, the Department of Health and Human Services and other Federal agencies. The Control Plan or Utilization Review Organization, as appropriate, shall have discretionary authority to interpret, apply and construe this provision of the Program. The Control Plan's or the Utilization Review Organization's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

S. "non-physician practitioners" means individuals other than physicians who are legally qualified and licensed to perform certain health care services. The following categories of non-physician practitioners may be eligible for reimbursement for services within their area of expertise. To be eligible for reimbursement, they must meet Program standards (including eligibility for reimbursement by Medicare for Medicare-eligible patients) and be approved by the carrier.

1. "certified registered nurse anesthetist" means a registered nurse trained in the administration of anesthetics.

2. "physical therapist" means an individual trained in the evaluation and rehabilitation of injured or disabled enrollees through non-medical and non-surgical measures.

3. "functional occupational therapist" means an individual trained in the restoration of a specified level of function of injured or disabled enrollees through non-medical and non-surgical measures.

4. "speech therapist" means an individual trained in the correction of speech and language disorders through non-medical and non-surgical measures.

5. "certified nurse mid-wife" means a registered nurse trained to provide obstetrical services who is legally qualified and registered, certified and/or licensed.

T. "orthotic appliance" means an external device intended to correct any defect of form or function of the human body.

U. "participating" or "approved" means any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, or other provider of health care services which, at the time an enrollee receives services included under this Program, has entered into a contract or agreement with a carrier to provide those health care services in accordance with this Program. Such contract or agreement shall include a provision that the provider accepts the amount of covered expense, as determined by the carrier, as payment in full (unless otherwise provided). A physician who is not a participating physician may participate for individual claims.

V. "physical therapy" and/or "functional occupational therapy" mean therapy directed toward improving or restoring the level of musculoskeletal function lost due to illness or injury, to the development of new function attainable following surgery, or, if for a chronic or congenital condition, to significantly improve the condition in a reasonable and predictable period of time. Physical therapy generally pertains to large muscle use and functional occupational therapy to fine motor activities.

W. "physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, physician shall also include the following categories of limited-practice professionals who are legally qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services which they are legally qualified to perform.

1. "dentist" means a doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention and treatment of diseases of the teeth and related structures. Such services are provided for under the dental coverage (see App. C of the Program). However, certain services of a dentist may be covered under this Appendix when provided in accordance with App. A, III.E.3.a.(2), or when performed in response to a medical diagnosis and when Program standards are met. A dentist also may prescribe medications which may be covered under

the prescription drug coverage (see App. A, III.G.).

2. "podiatrist" means a doctor of podiatric medicine (D.P.M.) or a doctor of surgical chiropody (D.S.C.) whose scope of practice is the diagnosis, prevention, and treatment of ailments of the feet. Services of podiatrists, relating to the foot (including the ankle), may be covered under the surgical and medical coverages (see App. A, III.E.). A podiatrist also may prescribe medications which may be covered under the prescription drug coverage (see App. A, III.G.).

3. "chiropractor" means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxations or misalignments of the spinal column and related bones and tissues which produce nerve interference. Services of chiropractors which may be covered are limited to diagnostic radiological services (see App. A, III.E.3.j.) and emergency first aid (as set forth in an administration manual published by the Control Plan), both pertaining to the spine and related bones and tissues.

Under this Program, a chiropractor may not prescribe medications or perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, nor perform physical examinations not related to the spine and related bones and tissues.

X. "private duty nursing" means care or services provided by a nurse pursuant to a contract with a patient and/or a patient's family/personal representative. The services may be skilled or unskilled, therapeutic or custodial in nature and may be provided in any setting. Generally, the care contracted for is in excess of the care provided by an institution (such as a hospital or skilled nursing facility) or the part-time/intermittent/skilled care provided by a home health care agency.

Y. "private room" means a room containing one bed.

Z. "Program standards" means criteria established by the Control Plan (and approved by the Corporation) for approval of providers or for benefit payment. At a minimum, providers must meet applicable accreditation, licensing and credentialing requirements and be qualified to render services or furnish materials under this Program. In the case of provider approval,

standards also may include, but are not necessarily limited to, such matters as approval for Medicare reimbursement and acceptance of Medicare assignment and/or Program reimbursement as payment in full. In the case of benefit payment, standards may include, but are not necessarily limited to, such matters as the service or item being approved by Medicare and/or the service or item being delivered or prescribed in response to particular diagnoses. Local carriers shall be responsible for establishing whether local providers conform to such standards, or for obtaining approval of exceptions through the Control Plan.

AA. "prosthetic appliance" means an artificial device which replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

BB. "rehabilitation care" means services within an acute care hospital or skilled nursing facility for intensive rehabilitation through a multidisciplinary, coordinated team approach. Such care is provided on an inpatient basis for patients found to have significant functional disability resulting from the recent onset of an acute condition (such as a broken hip or a stroke) or exacerbation of a chronic condition (such as rheumatoid arthritis), where there is a reasonable expectation for significantly increased function as a result of aggressive, inpatient, multi-modality rehabilitation services.

CC. "semiprivate room" means a room containing two beds.

DD. "service" means any care or procedure, as listed and limited herein, which is provided for diagnosis or treatment of disease, injury or pregnancy and which is based on valid medical need according to accepted standards of medical practice. Certain types of care or procedures may be excluded as covered services under this Program.

EE. "skilled nursing care" means care or services which are prescribed by a physician and furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN). The services may be provided on a continuous (as in a hospital or skilled nursing facility) or on an intermittent/part-time basis. The patient must be under treatment and/or convalescing from an illness or injury which requires ongoing evaluation and adjustment of care. The nature of the service and skills required for safe and effective delivery, rather than the patient's medical condition, determine whether the service is skilled.

Examples include, but are not limited to: administration of intravenous fluids and medications; suctioning; dressing changes for major post-operative wounds and dressing changes for infected lesions which require irrigation and/or medication and/or sterile dressings; catheterizations; ventilator care; cardio-pulmonary assessments; and colostomy/cystostomy care. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The carrier's determination as to the nature of care being provided shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with Program provisions or arbitrary and capricious.

FF. "skilled nursing facility" means a facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet Program standards and be approved by the local carrier.

GG. "special care unit" means a designated unit within a hospital (such as cardiac care, burn care, or intensive care unit) that concentrates all necessary types of equipment together with skilled nursing and supportive services needed for care of critically ill patients and is recognized as such by the carrier.

HH. "speech therapy" means therapy to restore the functional loss of speech resulting from an organic medical condition.

II. "therapeutic care" means specific and definitive surgical, medical, psychiatric or other care provided to a patient whose condition continues to improve due to the treatment being received. It is provided with the expectation that the patient's level of disability will

be reduced, within a reasonably predictable period of time, to enable the patient to function without such care. The improvement must be observable and documented by objective measurement. If a patient's condition stabilizes and further improvement is not reasonably predictable, continuing care will be considered maintenance in nature. The carrier's determination as to the nature of the care shall be given full force and effect unless it is determined by the Plan Administrator to have been contrary to the Program provisions or arbitrary and capricious.

JJ. "Utilization Review Organization" means an organization retained to perform certain utilization review and utilization management functions, including but not limited to predetermination, concurrent and retrospective utilization reviews.

II. Terms and Conditions

A. Payment of Benefits

1. Benefits will be payable, subject to the provisions of this Program, when an enrollee incurs a covered expense.

2. Under the Program, benefits for certain covered services are payable only if approved by the carrier and/or if furnished by approved providers, when applicable. If such approval is not obtained, or if such providers are not utilized, benefits for such services may be reduced or eliminated. Examples include, but are not limited to, failure to comply with the predetermination requirements or failure to utilize panel providers.

B. Benefit Period Provisions

1. An enrollee is entitled to a maximum of:

a. 365 days of covered inpatient hospital services for each continuous period of hospital confinement or for successive periods of confinement within a benefit period; however,

(1) the inpatient treatment of pulmonary tuberculosis is limited to 45 days of the benefit period; and

(2) the inpatient treatment of mental disorders and substance abuse (as set

forth in Appendix B) is limited to 45 days of the benefit period;

b. 210 days (lifetime maximum) of hospice care; and

c. two days of inpatient skilled nursing facility care for each remaining day of inpatient hospital care within the benefit period, to a maximum of 730 days for each continuous period of confinement or for successive periods of confinement within a benefit period. Each day of inpatient hospital care within a benefit period reduces by two the number of days of care available for skilled nursing facility services. Use of days of care in a skilled nursing facility does not reduce the number of days of inpatient hospital care.

2. Benefit periods for physician services and medical care related to hospital inpatient admissions and skilled nursing facility admissions are related to or may be determined concurrent with the benefit periods for facility services as noted below:

a. For conditions other than pulmonary tuberculosis, an enrollee is entitled to coverage for medical care for the duration of a hospital or skilled nursing facility admission.

b. Coverage of medical care for pulmonary tuberculosis is limited to 45 days for the treatment of tuberculosis for each continuous period of confinement or for confinements separated by less than 60 days.

3. Benefit periods may be renewed, subject to the following:

a. To be eligible for further benefits under each of the subsections, there must be a separation of 60 days between periods of hospitalization for any reason. For example, if an enrollee's initial inpatient admission for mental health treatment exhausts the 45-day maximum and is separated by 60 days from a second admission for mental health treatment, but the person had been hospitalized for other reasons during the intervening period, the second mental health admission would not be covered.

b. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of 60 days. Accordingly, there must be a lapse of at least 60 consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential substance abuse treatment facility, or any other facility to which the 60-day benefit renewal period applies and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits were paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse day or night care program, a substance abuse halfway house, a hospice program or is receiving home health care services, the 60-day renewal period is broken, whether or not benefits were paid as a consequence of receipt of such services.

C. Access to Information

In order to ensure proper administration and to facilitate the ongoing evaluation of this Program:

1. Enrollees shall authorize providers of services to furnish to the carrier(s), upon request, information relating to services to which the enrollee is, or may be, entitled under this Program.

   Providers of services shall be authorized to permit the carrier(s) to examine their records with respect to the services and to submit reports of the services in the detail requested by the carrier(s). All information related to treatment of the enrollee will remain confidential except for the purpose of determining rights and liabilities arising under this Program, or as otherwise required by law or pursuant to a written authorization by the patient.

2. A provider claiming payment from the carrier must furnish a report to the carrier, in the prescribed form, within 180 days from the date of the last continuous service listed on the report as having been rendered to the enrollee. The provider must certify upon the report that the provider is entitled to payment under this Program and that the service was personally rendered or rendered during the provider's presence and under the provider's

supervision. An enrollee's request for service is authorization to the provider to make the report.

3. An enrollee seeking payment from a carrier must furnish, or cause the provider to furnish, a report to the carrier in the form prescribed by the carrier. By filing the report the enrollee consents that the carrier may have access to the data disclosed by the records and files of the provider and of the hospital or other facility named in this report.

D. Identification Cards

1. Enrollees shall be furnished identification cards by the carrier(s). Such cards shall contain toll-free telephone numbers for obtaining predetermination information or other required approvals of services.

2. The identification card must be presented when service is requested.

3. An enrollee shall not use an identification card to obtain benefits to which such enrollee is not entitled, nor shall the enrollee permit another person to obtain benefits to which such person is not entitled.

E. Medicare

1. Under current Federal laws, certain enrollees otherwise eligible to enroll for benefits under Medicare may defer enrollment in Medicare without penalty. If such enrollees elect to enroll in Medicare, the Program remains the primary source of benefits, with Medicare supplementing Program coverage. For purposes of subsection 2 below, Medicare enrollment of such enrollees shall be disregarded.

2. Coverage under this Program is reduced to the extent that payment is available under Medicare, or to the extent that payment would have been available under Medicare but for the fact that Medicare payment is secondary to coverage provided by a source other than this Program. In the latter event, the maximum liability of this Program will be limited to the balance remaining after the liability of both the primary coverage and Medicare have been determined and benefits paid.

a. Enrollees who are eligible to enroll for benefits under Part A of Medicare, whether or not they are enrolled, will have all benefits available under this Program reduced to the extent payment or benefit is available (or would have been available had the eligible enrollee been enrolled for Medicare benefits) under Part A of Medicare. The hospital coverage under this Program will be reduced during the additional Medicare 60-day lifetime maximum for inpatient hospital benefits, to the extent the benefits are available under Medicare whether or not the enrollee uses the lifetime reserve.

b. Enrollees who are eligible to enroll for benefits under Part B of Medicare, whether or not they are enrolled, will have all benefits available under this Program reduced to the extent that payment or benefit is available (or would have been available had the eligible enrollee been enrolled for Medicare benefits) under Part B of Medicare.

c. All benefits furnished under Medicare Part A, or which would have been furnished had the enrollee been enrolled for Medicare Part A benefits, and all benefits furnished under Medicare Part B will be charged against the maximum benefit periods and maximum benefit amounts under this Program. Reduction of coverage under this provision or charging of Medicare benefits against the maximum benefit periods and maximum benefit amounts of this Program will be limited to the benefits provided by Medicare which would have been provided under this Program in the absence of this subsection.

3. If an enrollee, while covered under the Program, also enrolls for coverage under Part D of Medicare, such enrollee will be ineligible for coverage under the Program for as long as enrollment in Part D continues.

F. Medical Necessity and Appropriateness

1. All covered services under the Program are subject to a requirement of medical necessity (see App. A,I.R.).

2. The Control Plan will establish criteria, where necessary, to define medical necessity and accepted

uniform standards of medical practice for the purposes of determining covered services (except as set forth in subsection 4, below). The Control Plan shall propose such criteria to the Corporation, and when such criteria are approved, shall communicate them to the local carriers. Local carriers shall communicate the criteria to providers.

3. Local carriers, or others, requesting establishment, revision or withdrawal of such criteria shall submit such requests to the Control Plan for consideration. The Control Plan shall advise the Corporation of all such requests and recommended decisions.

4. Medical necessity and appropriateness criteria will be established by the Utilization Review Organization for those services which require predetermination.

G. Legal Action by Enrollee

Please refer to Article I, Section 6.

H. Changes in the Program

1. From time to time additional coverages may be provided or existing coverages withdrawn by the Corporation by action of its Board of Directors or other committee expressly authorized by the Board to take such action.

2. Neither the Control Plan nor a local carrier may make a substantive change to the coverages or benefits without prior approval of the Corporation. This includes amending administrative practices, policies or interpretations that in the judgment of the Corporation would materially affect the benefits of the Program.

I. Approval of New Services, Technologies and Provider Classes

1. A procedure has been established for implementing the addition of services or items not previously covered under this Program.

2. A proposal for the inclusion in the Program of a new or revised service or item may be submitted to the Control Plan by a carrier, a physician or physician group, a professional organization, a provider or provider group, or the Corporation.

3. The Control Plan shall review such proposal and make a written recommendation to the Corporation regarding whether or not the service or item should be added to the Program. Such recommendation shall include, but not be limited to, the following:

   a. Any quality of care concerns and proposed steps to ensure quality delivery of the service if approved;

   b. Any access concerns and proposed actions to resolve such concerns;

   c. Any concerns over appropriate utilization and proposed actions to resolve such concerns;

   d. Any service(s) being replaced by the new service, and a plan for discontinuation of coverage for the replaced service; and

   e. Positive or negative impact on Program costs.

4. The Corporation shall review and approve or disapprove the Control Plan recommendations. If approval is given and the service is added, an effective date will be established. Only services or items provided on or after the effective date will be covered.

5. The Control Plan will advise local carriers and other affected parties of any approved additions to the Program, the effective dates, and/or limitations or special provisions that apply. The local carriers will advise providers.

J. Participating, Nonparticipating and Departicipating Hospitals

1. When an enrollee's Basic Medical Plan (BMP) or Enhanced Medical Plan (EMP) option is administered by a carrier that has participating agreements with hospital providers, covered services provided to such an enrollee by a nonparticipating hospital (i.e., a hospital with which the carrier does not have a participating agreement), or by a departicipated hospital (i.e., a hospital whose participating agreement ceases, whether at the option of the provider, the carrier or both), are payable in accordance with the provisions set forth, respectively, in J.2. and J.3. below.

2. Benefits for covered services provided by a nonparticipating hospital (other than a psychiatric hospital) shall be payable as follows:

   a. Upon admission for a non-emergency condition, payment is limited to $230 per day for inpatient room and board charges and $20 per day for inpatient ancillary charges. Benefits are available for the duration of the admission, but in no event beyond the number of days available under the hospital benefit period.

   b. For an emergency admission (as defined by the Program):

      (1) Benefits will be payable for the reasonable charges (as determined by the carrier) for ground ambulance transfer to the closest participating hospital capable of handling the case, upon approval of the attending physician and the carrier. This approval must be based on the physician's medical certification that the transfer will not endanger the enrollee's health and of carrier certification that the subsequent stay will be of sufficient duration to justify the transfer.

      (2) When the enrollee cannot be safely moved to a participating hospital, the enrollee is entitled to benefits during the first five days of the admission, but in no event beyond the number of days available under the hospital benefit period.

      (3) Following the first five days of admission, payment is limited as described in 2.a. above. However, if transfer to a participating hospital cannot be arranged, either because such a transfer would endanger the enrollee's health or because the subsequent stay would not be of sufficient duration to justify transfer, benefits are payable for the duration of such admission, but in no event beyond the number of days available under the hospital benefit period.

c. Admissions to psychiatric hospitals are subject to the provisions of Appendix B of the Program.

d. Payment for outpatient services received at a nonparticipating hospital (other than a psychiatric hospital) is limited to $35 for each condition. Effective January 1, 1997, certain covered emergency services received in the outpatient department of a nonparticipating hospital will be paid on the same basis as if in a participating hospital. To qualify for payment, the claim must be for services related to a medical emergency or a serious bodily injury that requires immediate medical attention to avoid placing the enrollee's life in jeopardy, permanent damage to the enrollee's health or significant impairment of bodily functions. Treatment must be provided at the hospital immediately following the medical emergency or the injury. Payment will not exceed the amount that would be paid to a participating hospital, and there can be no assurance that the payment will cover the entire amount billed by the hospital.

3. The carrier will make efforts to notify enrollees of a hospital's departicipation and of the following payment arrangements:

a. For an enrollee whose hospital admission commences prior to, or within 30 days following, the date a participating hospital departicipates, benefits will be paid for the duration of such admission, but in no event beyond the number of days available under the hospital benefit period.

b. For an enrollee whose admission to such hospital commences later than 30 days from the date the hospital departicipates, payment for non-emergency admissions is limited as described in 2.a. above and payment for emergency admissions is limited as described in 2.b. above.

c. For an enrollee admitted to a departicipated hospital that regains participating status within six months of departicipating, the carrier will make payment toward the balance of the hospital's reasonable charges (as determined by the carrier) for covered

services incurred by the enrollee during the period of departicipation. The carrier shall also arrange that such payment relieves the enrollee of further financial obligation (other than the enrollee's deductible and/or copayment) with respect to covered services received during the departicipation period, and that any portion of such balance previously paid by the enrollee (other than the enrollee's deductible and/or copayment) shall be refunded.

K. Utilization Review Requirements

Utilization review functions are performed by carriers unless specifically assigned by the Corporation to a Utilization Review Organization. These review functions may include, but are not limited to, predetermination and concurrent, retrospective and focused utilization reviews. In some instances, special review processes will be developed and implemented, as necessary and practicable, to address specific utilization concerns.

The utilization review function assesses the medical necessity and medical appropriateness of services for coverage consideration. The carrier or Utilization Review Organization's determinations shall be given full force and effect unless determined by the Plan Administrator to be contrary to the Program provisions or arbitrary and capricious.

1. Predetermination is the process by which the medical necessity for a given health care service, appropriateness of the service, or the proposed setting for the services is reviewed, and the proposed treatment plan is either approved or disapproved by a carrier or Utilization Review Organization before performance of such service. The review is performed to examine pertinent medical documentation of the need, appropriateness and setting for such service. Predetermination is not a guarantee of benefit payment. To be covered, the service must meet all terms and conditions of the Program.

   (a) For enrollees in the Basic Medical Plan and Enhanced Medical Plan, the services listed below shall be reported by the enrollee (or by the provider on his or her behalf) to the Utilization Review Organization or carrier, as appropriate, for predetermination:

(1) Hospital admissions except maternity and emergency (Emergency admissions are to be reported to and reviewed by the Utilization Review Organization within 48 hours of inpatient admission.);

The predetermination of inpatient care includes the designation of appropriate lengths of stay based on diagnosis, patient characteristics, and/or appropriate practice patterns;

(2) Surgical procedures, regardless of place of service (Emergency outpatient surgical procedures are to be reported to and reviewed by the Utilization Review Organization within 48 hours of outpatient surgery.);

(3) Home health care services; and

(4) Skilled nursing facility admissions.

Enrollees in the Comprehensive Health Savings Plan and those receiving out-of-network services through the Point of Service Plan will be required to report the services in (1) and may be required by the carrier to report some or all of the services in (2), (3), and (4) for predetermination. Under the Point of Service Plan, network providers are responsible for obtaining any necessary pre-determinations.

(b) An appeal procedure will be available through the carrier or the Utilization Review Organization for medical review of disputed decisions prior to receipt of services. Decisions resulting from such an appeal procedure may be further appealed as set forth in Article I, Section 6.

(c) If services are determined to be not medically necessary, they are not covered under the Program and no benefits are payable.

(d) Benefits for covered services which require predetermination will be reduced by the lesser of $200 or the reasonable and customary charges prior to the application of deductible and copayment amounts, when necessary predetermination requirements are not met or the services are determined to be not

medically appropriate. Any such liability incurred by an enrollee is in addition to the deductible and copayment amounts (which shall be determined after applying this provision) and will not be applied to an enrollee's out-of-pocket expense for purposes of applying annual maximums. This provision is not applicable to the POS Plan when services are received in-network upon referral from the primary care physician, but is applicable if the services are deemed to be out of the POS network.

(e) Benefit reductions referred to in subsection (d) above shall not be applicable to an individual enrollee who has incurred three such reductions in a calendar year.

(f) Primary and secondary enrollees who have Medicare or another group health care plan as their primary coverage are not subject to the predetermination and review procedures set forth above.

2. Concurrent Utilization Review is the process by which the necessity, appropriateness and setting of a given health care service are reviewed while the patient is receiving inpatient care.

3. Retrospective Utilization Review is the process by which the necessity, appropriateness and setting of a given health care service are reviewed following the performance of the service. When retrospective review results in a determination that the admission or services were not medically necessary, recovery of any benefits paid for such admission or service will be made from the provider, subject to the limitations of the carrier's provider contracts. When the retrospective review results in a determination that the admission or services were not medically appropriate, a benefit reduction, as set forth in 1.(d) of this subsection, will be applied.

4. Focused Utilization Review is the process by which certain providers (professionals and facilities), procedures and/or diagnoses are reviewed to audit the necessity of a given health care service, appropriateness of the service, the setting of the service, the quality of care rendered, and the financial accuracy of claims submitted for reimbursement related to such services.

III. Description of Coverages

A. Hospital Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered expenses incurred in a hospital only if the following conditions have been met:

a. The admission and length of stay have predetermination approval from the Utilization Review Organization or carrier, as appropriate, for non-emergency, non-maternity admissions of enrollees in the Standard Medical Plan, Standard Plus Medical Plan, Point of Service Plan; Basic Medical Plan and Enhanced Medical Plan options, as set forth in Appendix A, II.K (emergency admissions must be reported to the carrier within 48 hours), or

b. Services are received on or after the enrollee's effective date of coverage under the Program.

c. For inpatient hospital services, the enrollee is admitted in accordance with the Program provisions, as administered by the carrier, and the hospital's rules and regulations governing admission as a bed patient, and is under the constant care and treatment of a physician during the period of admission.

d. For inpatient hospital services, the enrollee has benefit days available under the hospital benefit period as set forth in Section II.B. above.

2. Inpatient Hospital Coverage

Upon admission to a participating hospital, or to any hospital for carriers without participating arrangements, an enrollee is entitled to receive the following services when prescribed by the physician in charge of the case, approved by the Utilization Review Organization or carrier, as appropriate, and provided and billed by the hospital:

a. Semiprivate room, general nursing services, meals, and special diets. Private room coverage will be provided only when such

accommodations are medically necessary as set forth in an administration manual published by the Control Plan;

b. Use of operating rooms, other surgical treatment rooms, and delivery rooms;

c. Anesthesia services, anesthesia supplies, gases, and use of equipment;

d. Laboratory and pathology examinations which are under the direction of a pathologist employed by the hospital;

e. Chemotherapy (chemotherapeutics, antineoplastic agents and administration) for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is research, investigational or experimental in nature (See also Appendix A.III.L. regarding Centers of Excellence for non-routine cancer care);

f. Physical, speech, and functional occupational therapy (see App. A, III.C.);

g. Oxygen and other gas therapy;

h. Drugs, biologicals, and solutions used while the enrollee is in the hospital;

i. Gauze, cotton, fabrics, solutions, plaster, splints, and other materials used in dressings and casts;

j. Radioactive isotope studies and use of radium when the radium is owned or rented by the hospital;

k. Maternity care and routine nursery care of the newborn during the hospital stay of the mother for maternity care, when the mother is an enrollee. Coverage will comply with the Newborns and Mothers Health Protection Act of 1996;

l. Hospital service in a special care unit;

m. Blood services, including transfusions of whole blood and packed red blood cells (if not replaced), blood derivatives, blood plasma, supplies and their administration. Body

component preservation and storage for future use are not covered expenses;

n. Hemodialysis when provided by a hospital qualified to provide hemodialysis treatment. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The determination of the carrier as to whether or not a hospital is a qualified hospital for providing hemodialysis shall be given full force and effect unless it is determined by the Plan Administrator to have been contrary to the Program provisions or arbitrary and capricious;

o. Durable medical equipment (see App. A, III.I.);

p. Prosthetic and orthotic appliances (see App. A, III.I.);

q. Hospital services for mastectomy or sterilization of male or female enrollees, regardless of medical necessity;

r. Hospital services for covered plastic and reconstructive surgery (see App. A, III.E.3.a.(1));

s. Hospital services for abortions regardless of the medical necessity for the abortion;

t. Pulmonary function evaluation;

u. Skin bank, bone bank and other tissue storage bank costs;

v. Inhalation therapy; and

w. Human organ and tissue transplants. For medically recognized human organ or tissue transplants from a living or cadaver donor to a transplant recipient, hospital services (including evaluation tests to establish compatibility and suitability of potential and actual donors when the tests cannot be done safely and effectively on an outpatient basis) are covered as follows:

(1) When the transplant recipient and the donor are both enrollees, benefits are provided for both;

(2) When the transplant recipient is an enrollee, but the living donor is not, benefits are provided for the transplant recipient and, to the extent they are not available under any other health care coverage, for the donor;

(3) When the living donor is an enrollee and the transplant recipient is not, benefits are provided only for the donor;

(4) When the transplant recipient is an enrollee, expenses incurred in the evaluation and procurement of cadaver organs and tissues are benefits when billed by the hospital. All such expenses will be charged to the enrollee's coverage to the extent that they are not covered by any other health care coverage of the donor or potential donor;

(5) For purposes of this subsection w. and of App. A, III.E.3.a.(3), "medically recognized" human organ or tissue transplants include allogeneic bone marrow for only specified diagnoses, autologous bone marrow for only specified diagnoses, cornea, heart, heart/lung, kidney, liver, lung, pancreas and skin. The limitations with respect to bone marrow transplants are contained in Section IV.Z. of this Appendix. See also Appendix A,III.L. regarding Centers of Excellence for human organ transplants.

3. Outpatient Hospital Coverage

a. When an enrollee receives outpatient hospital services in a participating hospital, or any hospital for carriers without participating arrangements, which have been ordered by the attending physician and approved by the carrier (or Utilization Review Organization for services that require predetermination), the enrollee is entitled to the same coverages available on an inpatient basis, except that:

(1) Drugs, biologicals, and solutions are covered only to the extent they are used

in the hospital and administered in connection with the use of operating or surgical treatment rooms, anesthesia, laboratory examinations, other outpatient hospital services, or, as of October 1, 1999, IV infusion therapy services.

(2) Physical, speech and functional occupational therapy also may be covered (see App. A, III.C.).

(3) Chemotherapy (chemotherapeutics, antineoplastic agents and necessary ancillary drugs and their administration) is covered for the treatment of malignant diseases except when the treatment is research, investigational or experimental in nature.

Chemotherapy is covered for the following routes of administration: parenteral, continuous or intermittent infusion, perfusion, and intracavitary. Coverage is not available for the oral administration of chemotherapy.

(4) Coverage does not include treatment of chronic conditions which require repeated visits to the hospital, except for hemodialysis and, as of October 1, 1999, IV infusion therapy services.

(5) Services in the emergency room of a hospital are covered for the initial examination and treatment of conditions resulting from accidental injury or medical emergencies. A medical emergency will be considered to exist only if medical treatment is secured within 72 hours after the onset of the condition. Follow-up care is not covered, with the exception of follow-up care for rabies exposure.

If an emergency room patient is placed under observation care, hospital services are covered when such services are reasonable and necessary to evaluate a patient's condition or determine the need for possible admission to the hospital. Coverage for such services is

generally limited to 24 hours, unless the medical necessity of additional time is documented in the medical records and approved by the carrier.

(6) Hyperbaric oxygenation is covered when medically necessary for treatment of disease or injury. Coverage is not available for treatment of chronic conditions.

(7) Skin bank, bone bank and other tissue storage bank services are not covered.

b. Hemodialysis (use of kidney machine) or peritoneal dialysis for the treatment of a chronic, irreversible kidney disease is covered in an enrollee's home when services are provided and billed by a hospital which has a hemodialysis program approved by the carrier.

(1) Benefits will not be payable unless the following conditions are met:

(a) treatment must be arranged through the physician attending the enrollee and the physician director or a committee of staff physicians of the training program, and

(b) the owner of the enrollee's residence must give written permission to the hospital for installation of the equipment prior to its installation.

(2) The following are covered expenses under this subsection:

(a) purchase, lease, or rental (as determined by the carrier to be appropriate) of a hemodialysis machine placed in the enrollee's home;

(b) installation and maintenance or repair of a hemodialysis machine placed in the enrollee's home;

(c) hospital expenses for training the enrollee and any individual who will be assisting the enrollee in

the home setting in operating the hemodialysis machine;

(d) laboratory tests related to the dialysis procedure;

(e) consumable and expendable supplies required during the dialysis procedure, such as dialysis membrane, solution, tubing, and drugs; and

(f) removal of the dialysis equipment from the enrollee's home when the enrollee no longer needs the equipment.

(3) The following are not covered expenses under this subsection:

(a) services not provided and billed by a hospital with a hemodialysis program approved by the carrier;

(b) reimbursement to individuals trained and assisting in the dialysis procedure;

(c) electricity or water used in operating the dialyzer;

(d) installation of electric power, a water supply, or a sanitary waste disposal system in conjunction with installing the dialysis equipment;

(e) physician's services, except to the extent the physician is reimbursed by the hospital for administration and overall supervision of the program;

(f) transfer of the dialyzer to another location in the enrollee's residence;

(g) services performed prior to the effective date of the home hemodialysis program; and

(h) services provided by an agency or organization providing "back-up" assistance in home hemodialysis,

including the services of hospital personnel sent to the enrollee's home, or of other persons under contract with the hospital.

4. Limitations and Exclusions

a. Coverage for hospital admissions and services is only for the period which is medically necessary for the proper care and treatment of the enrollee, subject to the maximum benefit period and other applicable Program provisions. As a condition of continued hospital coverage, the carrier or Utilization Review Organization may require written verification by the physician in charge of the case of the need for services. For purposes of this subsection and subsection 4.b. below, the carrier or Utilization Review Organization shall review the severity of the patient's illness and the nature and intensity of services required/provided and, based upon such review, shall have discretionary authority to interpret, apply and construe these provisions of the Program. The carrier's or Utilization Review Organization's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

b. Coverage does not include hospital services related to domiciliary, custodial, convalescent, nursing home, or rest care.

c. Coverage does not include hospital services consisting principally of dental treatment or extraction of teeth, as provided in Appendix A, III. E.3.a.(2).

d. Coverage does not include inpatient hospital services when the care received consists principally of observation or diagnostic evaluations, inpatient physical, functional occupational or speech therapy, x-ray examinations, laboratory examinations, electrocardiography or basal metabolism tests, ultrasound studies, nuclear medicine studies, weight reduction by diet control with or without medication, or environmental control.

e. Coverage for hospital services does not include services of physicians, oral surgeons, or services covered elsewhere in this Appendix, such as x-ray examination or therapy, electrocardiography, cobalt, or ultrasound studies.

f. The enrollee must give notice of coverage to any hospital at the time of admission. If notice is not given at that time, the enrollee may be liable for a portion of charges incurred.

g. If an enrollee cannot obtain admission to participating or nonparticipating hospitals, the carrier may pay the enrollee an amount not to exceed $65 for the expense of nursing and other services and supplies, restricted to the equivalent of hospital care made necessary by the illness or injury. The payment shall be full satisfaction of all obligations of the carrier and the participating hospitals to furnish hospital service for the disability for which admission was sought; provided, however, that if the admission is for the care of contagious or epidemic disease, or injury due to war, declared or undeclared, the Corporation, the carriers and the participating hospitals are under no obligation or liability under this Program.

h. Hospital coverage does not include facility charges for care received in an urgent care center.

i. Hospital coverage does not include facility charges for care received in a freestanding ambulatory surgery center, unless such center meets Program standards and is approved by the carrier.

j. Hospital coverage does not include facility charges related to refractive eye surgery (e.g., radial keratotomy, corneal sculpting or similar surgical procedures to correct vision), sterilization reversals or non-covered plastic, cosmetic, or reconstructive surgery.

k. Hospital coverage does not include positron emission tomography (PET) scanning services.

l. Coverage for hospital services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

B. Skilled Nursing Facility Coverage

1. Conditions of Benefit Payments

All skilled nursing admissions must be predetermined by the Utilization Organization or carrier, as appropriate.

An enrollee is eligible for benefits for covered expenses incurred in a skilled nursing facility only if the following conditions have been met:

a. The services are received on or after the enrollee's effective date of coverage under this Program.

b. The admission has been approved by the Utilization Review Organization or carrier, as appropriate, and the enrollee is admitted to the skilled nursing facility by the order of a physician who certifies that the enrollee requires the type of care available at the facility.

c. The enrollee has benefit days available under the skilled nursing facility benefit period (see App. A, II.B.).

d. The care received by the enrollee consists of definitive medical, nursing, or other paramedical care.

2. Coverages

a. Upon admission to a skilled nursing facility approved by the carrier, an enrollee is entitled to receive the following services when prescribed by the physician in charge of the case and when provided and billed by the facility:

(1) Semiprivate room, general nursing service, meals, and special diets;

(2) Use of special treatment rooms;

(3) Routine laboratory examinations;

(4) Physical, speech, or functional occupational therapy when medically necessary for the treatment of the enrollee (see App. A, III.C.);

(5) Oxygen and other gas therapy;

(6) Drugs, biologicals, and solutions used while the enrollee is in the facility;

(7) Gauze, cotton, fabrics, solutions, plaster, splints and other materials used in dressings and casts; and

(8) Durable medical equipment (see App. A, III.I.).

b. Medical care in skilled nursing facilities: Coverage is provided for medical care approved by the Utilization Review Organization or carrier, as appropriate, in a skilled nursing facility by the physician in charge of the case. Care is subject to the 730-day benefit period maximum. Medical care in a skilled nursing facility for the treatment of tuberculosis or substance abuse is not covered.

3. Limitations and Exclusions

a. Skilled nursing facility admissions and services are covered only when the services are medically necessary. As a condition of continued skilled nursing facility coverage, the Utilization Review Organization or carrier, as appropriate, may require written verification by the physician in charge of the case of the need for services. For the purposes of this subsection and of subsection 3.b., below, the Utilization Review Organization or carrier shall review the severity of the patient's illness and the nature and intensity of the services required/provided and, based upon such review, shall have discretionary authority to interpret, apply and construe these provisions of the Program. The exercise of this authority by the Utilization Review Organization or the carrier shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

b. Coverage is not provided for care which is principally custodial or domiciliary or for care of tuberculosis.

c. Notwithstanding a. and b. above, for the period of time the Program is secondary to the payment of Medicare benefits for skilled nursing facility services, Medicare's determination of coverage will be deemed to satisfy Program criteria as to medical necessity and maintenance, domiciliary and custodial care. However, if the carrier or Control Plan become aware of the admission during such period of time, the Control Plan, or another designated party, shall review the admission and advise the enrollee as to ongoing coverage before the exhaustion of Medicare benefits.

d. Coverage for skilled nursing facility services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

C. Physical, Functional Occupational and Speech Therapy and Cardiac Rehabilitation Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered physical, functional occupational and speech therapy and cardiac rehabilitation expenses only if the following conditions have been met:

a. Services are received on or after the enrollee's effective date of coverage in this Program;

b. Services are approved by the carrier, prescribed by the physician in charge of the case, and provided or supervised by a physician (other than a limited-practice physician) or by a registered and licensed physical, occupational or speech therapist for the specific therapy prescribed;

c. Services are provided and billed by a physician (other than a limited-practice physician) or a hospital, or a freestanding outpatient physical therapy facility, home health care agency, skilled nursing facility,

or independent therapist approved by the carrier; and

d. Benefits are available during the benefit period for covered hospital or skilled nursing facility inpatient care.

2. Coverages

Services are covered as follows:

a. Physical Therapy and Functional Occupational Therapy

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee is entitled to receive physical and functional occupational therapy to the extent medically necessary for the treatment of the condition for which the enrollee is admitted. If rehabilitation care is prescribed and approved, the rehabilitation program is expected to include, at a minimum:

(a) Medical care and supervision by a physician with specialized training and/or experience in rehabilitation, with 24-hour per day physician availability in addition to physician evaluation of the patient at least three times per week;

(b) The active involvement in the patient's care of a nurse with specialized training and/or experience in rehabilitation nursing (including 24-hour immediate, on the premises, availability of a registered nurse with specialized training and/or experience in rehabilitation nursing);

(c) Social work services;

(d) Physical therapy services;

(e) Plus one or more of the following:

(i) occupational therapy;

(ii) speech therapy;

(iii) psychological services;

(iv) prosthetic and/or orthotic fabrication and fitting.

(2) Enrollees are entitled to receive physical therapy and functional occupational therapy provided through an approved home health care agency. When special equipment not easily made available in the home is required, an enrollee is entitled to coverage for such services in a hospital or freestanding outpatient physical therapy facility participating with the home health care agency when related to the condition for which the enrollee was admitted to the home health care program.

(3) Physical therapy and/or functional occupational therapy are covered on an outpatient basis when performed to restore or improve musculoskeletal function.

b. Speech Therapy

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee is entitled to receive speech therapy on the same basis as described in subsection 2.a.(1) above.

(2) Enrollees are entitled to receive speech therapy provided through an approved home health care agency.

(3) Restorative speech therapy (speech pathology) is covered on an outpatient basis when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the enrollee's illness. Speech therapy is not covered for long-standing, chronic conditions, or inherited speech abnormalities except as set forth in subsection b.(4) below.

(4) Speech therapy for congenital and severe developmental speech disorders is

covered when not available through other public agencies (e.g., state or school).

(a) In order to be covered, the enrollee must be diagnosed as having a severe communicative deficit as defined by Program standards.

(b) Speech therapy is not covered for:

(i) educational learning disabilities (e.g., dyslexia);

(ii) deviant swallow or tongue thrust;

(iii) mild developmental speech or language disorders;

(iv) congenital deafness;

(v) elimination of a lisp, or similar defect in articulation; or

(vi) improving speech that is not fully developed.

(c) Initial and interim patient assessment to determine severity of condition, potential for improvement, progress and/or readiness for discharge from treatment is considered part of the overall treatment program and is a covered service when accompanied by treatment.

(d) Steady improvement as a consequence of treatment must be documented in periodic interim reports. Such documentation must be available to the carrier upon request.

c. Cardiac Rehabilitation

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee may receive cardiac rehabilitation on the same basis as therapy described in subsection 2.a.(1) above.

(2) Enrollees may receive cardiac rehabilitation on an outpatient basis provided through a hospital or performed or supervised and billed by a physician. The payment of benefits for cardiac rehabilitation on an outpatient basis is limited to services provided during the six-month period immediately following acute myocardial infarction, initial diagnosis of angina pectoris, or certain heart surgeries.

3. Limitations and Exclusions

a. Covered expenses will not include and benefits are not payable for:

(1) physical, functional occupational and/or speech therapy services if:

(a) such services are provided without expectation that the condition will improve in a reasonable and generally predictable period of time,

(b) improvement does not occur, as documented in the patient's record on a periodic basis, or

(c) progress is no longer being made or the previous level of function has been restored;

(2) physical therapy and/or functional occupational therapy provided solely to maintain musculoskeletal function;

(3) occupational therapy which is not functional in nature;

(4) inpatient admissions which are principally for physical, functional

occupational and/or speech therapy or for cardiac rehabilitation;

(5) manipulation, adjustment or massage of the musculoskeletal system;

(6) vision therapy or training;

(7) cognitive rehabilitation which includes, but is not limited to, vocational rehabilitation, recreational therapy, learning exercises for retraining in routine activities of life or aspects of cognitive functioning such as concentration, organizational skills, information processing, memory, thinking, and problem solving;

(8) day, night or residential rehabilitation programs;

(9) services which could be performed by an untrained, unlicensed person, by the enrollee, or by a member of the enrollee's family;

(10) isokinetic testing or treatment;

(11) debridement and cleansing with whirlpool for first or second degree burns;

(12) physical and/or functional occupational therapy for first and second degree burns.

b. Coverage for physical, functional occupational and speech therapy and cardiac rehabilitation is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

D. Home Health Care Coverage

1. Conditions of Benefit Payments

Home health care services are subject to predetermination by the Utilization Review Organization or carrier, as appropriate. An enrollee is eligible for benefits for covered expenses incurred for home health care services only if the following conditions have been met:

a. The home health care services are received on or after the enrollee's effective date of coverage in this Program;

b. The enrollee is referred to and accepted by a home health care agency that meets Program standards and is approved by the local carrier;

c. The services received are approved by the Utilization Review Organization or carrier, as appropriate, prescribed by the physician in charge of the case and provided and billed by an approved provider;

d. The physician in charge of the case certifies to the carrier that skilled home health care services are medically necessary for the care of the enrollee; and

e. The enrollee is essentially homebound for medical reasons and physically unable to routinely obtain the needed medical services on an outpatient basis without special assistance. The homebound requirement does not apply to covered IV infusion therapy services.

2. Coverages

a. The following services are covered when provided on a part-time or intermittent basis during a home health care visit and billed by a home health care agency approved by the carrier:

(1) General nursing services;

(2) Physical therapy and speech therapy (may be provided and billed by a hospital outpatient department or a carrier-approved physical therapy provider under limited circumstances - see App. A, III.C.2.);

(3) Social service guidance, dietary guidance, and functional occupational therapy; and

(4) Services by a home health aide employed by an approved home health care agency. To be eligible for home health aide service, the enrollee must be receiving

one of the services in (1) or (2) above, and it must be determined by the home health care agency and the Utilization Review Organization or carrier, as appropriate, that the enrollee could not be treated under this subsection without the home health aide service.

b. For the purposes of this subsection III.D.:

(1) A home health care visit consists of a visit

(a) to the enrollee's home by any member of the home health care team for the purpose of providing necessary professional service;

(b) to the enrollee's home by a home health aide for the purpose of providing covered home health aide services as described in subsection 2.a.(4) above; or

(c) by the enrollee to a hospital or skilled nursing facility or approved physical therapy provider as an outpatient for speech evaluation or physical therapy when required equipment is not easily available for home use;

(2) "part-time care" means:

(a) up to and including 28 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day; or

(b) up to 35 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day, subject to individual review and approval by the Utilization Review Organization or carrier, as appropriate, based on diagnosis, prognosis and documented improvement in the patient's condition; and

(3) "intermittent care" means:

(a) part-time care as described in subsections (2)(a) and (b) above, which is provided on less than a daily basis; or

(b) up to eight hours per day of skilled nursing and home health aide services combined, delivered on a daily basis, for a temporary period not to exceed one month, subject to review and approval by the Utilization Review Organization or carrier, as appropriate, based on diagnosis, prognosis and documented improvement in the patient's condition.

c. The following services are covered when provided and billed by an approved provider:

(1) Laboratory tests;

(2) Drugs, biologicals, and solutions; and

(3) Medical supplies which are essential in order to effectively administer in the home the medical regimen ordered by the physician. Supplies include items such as bandages, dressings, splints, hypodermic needles, catheters, colostomy appliances, and oxygen. When covered home health care services are being provided, medical supplies used in the home for the patient's care will be covered under this section, even if used during a portion of the day or week when nursing services are not covered.

d. IV infusion therapy services in the home are covered under home health care coverage. The following provision will apply to such services:

(1) The "homebound" requirement will be waived with respect to home infusion therapy patients;

(2) Related nursing services will be included;

(3) Applicable prescription drugs will be included;

(4) All services directly related to infusion therapy, including DME, parenteral and enteral methods of hyperalimentation, chemotherapy, and supplies, will be covered under Home Health Care coverage;

(5) The provision that limits home health care benefits to three visits for each remaining inpatient hospital day will be waived; and

(6) Home IV infusion therapy services will be covered only when delivered by a provider that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. Limitations and Exclusions

a. Coverage for home health care services is available only when the services are medically necessary. As a condition of continued home health care coverage, the Utilization Review Organization or carrier, as appropriate, may require written verification by the physician in charge of the case of the need for services. The Utilization Review Organization or carrier, as appropriate, shall have discretionary authority to interpret, apply and construe this provision of the Program. The Utilization Review Organization's or carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

b. Coverage under this subsection does not include supplies such as elastic stockings, personal comfort or personal hygiene items or equipment, or supplies and appliances which may be covered under the durable medical equipment and prosthetic or orthotic appliance provisions (such as hospital beds, oxygen tents, walkers, wheelchairs, or orthotics).

c. Coverage under this subsection does not include physician services, private duty nursing services or housekeeping services.

d. Coverage under this subsection does not include skilled nursing services and home health aide visits when the care exceeds the part-time or intermittent levels.

e. Coverage under this subsection does not include home uterine monitoring.

f. Coverage under this subsection does not include charges for travel time.

g. The maximum amount of reimbursable expense for home health care services under this subsection is limited to the amount which would be reimbursable for similar care rendered in a skilled nursing facility.

h. Coverage for physical, functional occupational, and speech therapy provided in accordance with subsection D.2.a. (2) and (3) above are subject to the limitations and exclusions in Appendix A, III.C.3.

i. Coverage for home health care services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

E. Surgical and Medical Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for expenses incurred for surgical and medical covered services only when the following conditions have been met:

a. Services are received on or after the enrollee's effective date of coverage in this Program;

b. Services are approved by the carrier, when necessary (or the Utilization Review Organization for services that require predetermination); and

c. Services are received prior to the termination date of the enrollee's coverage, except that services received during hospital admissions which commence prior to such termination date will be covered subject to other provisions of this Program.

2. Payment of Services

a. The carrier(s) will make payment according to a fee schedule, capitation schedule, or reasonable and customary charges.

b. A carrier will make the benefit payments directly to the provider for services performed or materials furnished by such provider, or directly to the enrollee if appropriate.

c. The carriers shall have discretionary authority to interpret, apply and construe these reimbursement provisions of the Program. A carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious. The carrier will defend its determination of the fee, capitation rate or reasonable and customary charge if a provider claims an amount in excess of the carrier's determination from the enrollee and there is no payment or prior written agreement between the patient and the provider regarding the amount of the provider's charges.

d. Certain hospital-based physician services billed by a hospital will be paid directly to the hospital by a carrier according to the carrier's agreement with the hospital.

3. Coverages

Except as otherwise indicated, the following services are covered:

a. Surgery: Subject to the limitations listed below, surgical services, consisting of generally accepted operating and cutting procedures for the necessary diagnosis and treatment of diseases, injuries, fractures, or dislocations, are covered when performed by the physician in charge of the case.

Surgical services require predetermination as described in Appendix A.II.K.

Surgical services include usual, necessary, and related preoperative and postoperative care performed in or out of the hospital.

(1) Plastic and reconstructive surgery is limited to the correction of congenital anomalies and conditions resulting from accidental injuries or traumatic scars, to the correction of deformities resulting from cancer surgery or following medically necessary mastectomies (including medically necessary mastectomies resulting from cancer or fibrocystic disease), and to blepharoplasties when there is visual impairment.

Notwithstanding the above, in compliance with the Women's Health and Cancer Rights Act of 1998, in the case of an enrollee who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, coverage includes: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

(2) Dental surgery is limited to multiple extractions, removal of one or more unerupted teeth, alveoloplasty, or gingivectomy, and is covered only when performed in a facility setting (i.e., hospital inpatient or outpatient or Freestanding Ambulatory Surgical Center), when a concurrent hazardous medical condition exists and when Program Standards are met. Surgical procedures to excise tumors or cysts of the oral cavity, to correct fractures of facial or jawbones, dislocations and disorders of joints, or to correct accidental injury are not considered dental surgery and are considered in accordance with the general surgery provisions above.

(3) For medically recognized human organ or tissue transplants [see App. A, III.A.2.w.(5)] from a living or cadaver donor to a transplant recipient which

requires surgical removal of a donated part, benefits for services as listed and limited in this subsection (including laboratory services for evaluation tests to establish a potential donor's compatibility and suitability) will be covered in the same manner as under Section III.A.2.w.

Payments will be reduced by any amount payable from other sources, such as foundations, grants, governmental agencies or programs, research or educational grants and charitable organizations.

Centers of Excellence Facilities, as describe in Appendix A.III.L., may be utilized, where appropriate, for covered human organ or tissue transplants.

(4) Surgical procedures for mastectomy or for sterilization of male and female enrollees irrespective of medical necessity are covered. Sterilization reversals are not covered.

(5) Laser surgery is covered if the alternative cutting procedure is covered. The maximum benefit payable for laser surgery is the reasonable and customary charge for the alternative cutting procedure.

b. Hemodialysis: Services are covered only when performed by a physician in a facility meeting Program standards and approved by the local carrier or in the enrollee's home.

c. Anesthesia: Services for the administration of anesthetics are covered, when provided by a physician, other than the operating physician, and when required by, and performed in conjunction with, another covered service.

(1) Anesthesia services provided by a physician for covered services are payable in all settings that are appropriate for the covered surgical or diagnostic service being performed, including inpatient hospital, outpatient hospital, freestanding ambulatory surgical center, and physician's office.

(2) Anesthesia services include the administration of anesthesia by a Certified Registered Nurse Anesthetist (CRNA) or an Anesthesia Assistant (AA) working under the medical direction of an anesthesiologist who is available for immediate attendance. CRNA services are also covered if performed under the general supervision of a physician who is not an anesthesiologist and who is available for immediate attendance. .

(3) CRNAs must attain specialty certification from the Council on Certification of Nurse Anesthetists and be state licensed. AAs must be graduates of an educational program accredited by the Commission on Accreditation of Allied Health Education Programs, be certified by the National Commission for the Certification of Anesthesiologists Assistants and the National Board of Medical Examiners, and work under the supervision of a licensed MD or DO who is responsible for overall provision of anesthesia to the patient. Anesthesia services performed by CRNAs or AAs are payable in the inpatient hospital, outpatient hospital or free-standing ambulatory surgical center settings.

(4) Administration of local anesthetics is not covered. Anesthesia services, supplies, gases and use of equipement provided by a hospital are covered only under Section III.A.2.c.

d. Technical surgical assistance: Services by a physician or a physician assistant who actively assists the operating physician are covered when medically necessary and when related to covered surgical or maternity services. In order for the services of the assistant surgical physician or a physician assistant to be covered, it must be certified that the services of interns, residents, or house officers were not available at the time. In order for technical surgical assistance performed by a physician assistant to be covered, the physician assistant must be legally qualified and registered, certified

and/or licensed, as applicable, to perform these health care services. The physician assistant must meet Program standards and be approved by the carrier. Reimbursement for technical surgical assistance services performed by a physician assistant will be made to the employer of the physician assistant.

e. Maternity care: Obstetrical services of a physician or a certified nurse mid-wife, including usual prenatal and postnatal care, are covered. For each pregnancy, coverage is also provided for routine prenatal laboratory examinations which are performed in connection with normal maternity care. Covered obstetrical services provided by a certified nurse-midwife are limited to basic antepartum care, normal vaginal deliveries, and postpartum care. For a given uncomplicated pregnancy, reimbursement for such care would be to the physician or the certified nurse-midwife, but not both. Certified nurse-midwives are reimbursed only for deliveries occurring in the inpatient setting or in a birthing center that is hospital affiliated, state licensed and accredited and approved by the carrier. The certified nurse-midwife must be legally qualified and registered, certified and/or licensed, as applicable, to perform these health care services. The nurse-midwife must meet Program standards and be approved by the carrier. Coverage includes:

(1) the examination of a newborn child by a physician other than the delivering physician, certified nurse mid-wife or the physician administering anesthesia during delivery; and

(2) obstetrical services of a physician for an abortion.

f. Consultations: When requested by the physician in charge of the case, coverage is provided for the assistance of a physician in the diagnosis or treatment of a condition which requires special skill or knowledge. This coverage does not include phone consultations or staff consultations required by a facility.

g. Chemotherapy: Coverage for chemotherapy is provided under App. A, III.A.2.e. for inpatient care and under App. A, III.A.3.a.(3) for outpatient care. Chemotherapy administered in a physician's office is covered on the same basis as outpatient and excludes services which are research, investigational or experimental in nature. (See also Appendix A, III.L. regarding Centers of Excellence for non-routine cancer care.)

h. Extra-corporeal shock wave lithotripsy (ESWL): Coverage is provided for services rendered in a carrier-approved facility meeting Program standards.

i. Therapeutic radiology: Coverage is provided for treatment of conditions by x-ray, radium, radon, external radiation, or radioactive isotopes (e.g., cobalt), and includes the cost of materials provided which are not supplied by a hospital.

j. Diagnostic radiology: Coverage is provided if approved by the carrier as required, for diagnosis of any condition, disease, or injury by x-ray, ultrasound, isotope examination, computerized axial tomography (CAT), magnetic resonance imaging (MRI) and positive emission tomography (PET) scanning, mammography and other modalities. Coverage restictions include, but are not limited to the following:

(1) Computerized axial tomography is covered for diagnostic examinations of the head and body when ordered by a physician and performed on approved equipment in accordance with Program standards.

(2) Digital subtraction angiography is covered if performed on hospital based equipment.

(3) Magnetic resonance imaging (MRI) and positive emission tomography (PET) scanning coverage is provided in accordance with Program standards, which include diagnosis restrictions and the use of carrier-approved facilities.

(4) Positron emission tomography (PET) is a covered procedure when performed in accordance with Program standards for

covered conditions and approved providers.

(5) The maximum benefit payable for digital mammography is the reasonable and customary charge for the alternative standard film mammogram.

k. Laboratory, pathology and other services: Coverage is provided if approved by the carrier for laboratory and pathological examinations for the diagnosis of conditions, diseases, or injuries or for performing covered well child care services and physical examinations. In addition to examinations of blood, tissue, and urine, diagnostic laboratory and pathology coverage includes laboratory procedures such as electrocardiograms, electroencephalograms, electromyograms, and basal metabolism tests.

(1) Routine laboratory services in connection with normal maternity care are covered according to the provisions of Section III.E.3.e.

(2) Hearing aid evaluation tests are covered only under Section III.H. of this Appendix.

(3) Audiometric examinations may be covered, but are subject to the exclusions of Appendix A, III.H.5.a., d., e., g., h., i., j., k., and l.

l. Physician medical visits: Coverage is provided for medical visits by a physician when rendered in the physician's office, the home, a hospital, or a skilled nursing facility for the examination, or diagnosis and treatment of any condition, disease or injury subject to the provisions below.

(1) Inpatient medical care is covered when provided by the physician in charge of the case. Services of a physician who is treating a condition unrelated to the reason for the admission may also be covered.

(2) Treatment rendered in or at a hospital is covered only when provided by a

physician who is not an employee of the hospital.

(3) Well childcare is covered for enrollees six years of age or younger.

(4) Routine physical examinations are covered for enrollees over six years of age and are limited to one each calendar year.

(5) Physician medical visit coverage does not include services or separate charges for the following (although some of the items may be covered under other provisions of the Program):

(a) mental health or substance abuse treatment;

(b) prenatal and postnatal care;

(c) immunizations;

(d) routine eye examinations;

(e) insurance, employment and premarital examinations;

(f) manipulation, adjustment or massage of the musculoskeletal system;

(g) allergy testing, treatment or injections;

(h) weight control;

(i) acupuncture; or

(j) services provided by non-physician practitioners, e.g., Physician Assistants, Christian Science practitioners, etc.

m. Immunizations and injections: Coverage is provided for medically recognized immunizations and injections as approved by the carrier.

(1) Serum is covered only when it is not supplied by a health department or other public agency.

(2) Vitamin and iron injections are covered only when required and necessary for diagnosed illness.

(3) Injections for chelation therapy are not covered, unless they meet Program standards as to diagnosis and the nature of the service(s) performed. Chelation therapy by means other than injection may be covered under other provisions of the Program.

(4) Allergy injections are not covered.

(5) Injections covered under another Section of this Appendix (e.g., chemotherapy) are not covered.

n. Foot care: Coverage is provided for treatment of injuries and/or infections of the feet. Routine foot care (e.g., cutting, paring, debridement and curettement of nails, corns, calluses and other hyperkeratotic or benign lesions and treatment of mycotic toe nails) is covered only for enrollees with a confirmed diagnosis of diabetes or peripheral vascular disease and is subject to Program standards regarding frequency.

o. Screening examinations: Coverage is provided in accordance with the provisions of subsections E.3.j. and k., above, for appropriate examinations and procedures prescribed by a physician and performed solely for early detection of a pathological condition in an otherwise asymptomatic individual. However, the deductible and copayment provisions otherwise applicable to services performed for enrollees of particular options, under Article II, Section 4 of the Program, do not apply to:

(1) laboratory and pathological services for one routine Papanicolau (PAP) smear per enrollee per calendar year to detect cancer of the female genital tract,

(2) one proctoscopic exam without biopsy performed within each three calendar year period after age 40 is attained, or

(3) one routine screening or diagnostic mammogram per calendar year for

enrollees age 40 and older who meet Program standards.

(4) one screening or diagnostic prostate specific antigen (PSA) test per calendar year for enrollees age 40 or older who meet Program standards.

(5) one routine screening or diagnostic sigmoidoscopy or barium enema X-ray every five calendar years or one colonoscopy every 10 calendar years for enrollees age 50 or over.

(6) one routine screening or diagnostic fecal occult blood test per calendar year for enrollees age 50 or over.

(7) One routine screening or diagnostice total serum cholesterol test every five calendar years for enrollees age 20 or over.

(8) When a covered diagnostic test requires injection of a drug, biological or solution in order to perform the test, the drug, biological or solution and the injection of it are covered, subject to carrier billing and reimbursement practices. For purposes of this subsection only, injections of thyrogen are covered in conjunction with covered thyroid scans.

p. Contraceptive services: Medical and surgical coverage for contraceptive services is limited to injections of contraceptive medication (professional fees and medication for injection), implantable contraceptives and their insertion or removal, intrauterine devices and their insertion or removal, cervical caps and their fitting, and the fitting of diaphragms. Coverage under this Section does not include over-the-counter contraceptive devices or diaphragms. (See Appendix A. III.G. for prescription drug coverage provisions regarding oral contraceptives, injectable contraceptive medication, contraceptive patches and diaphragms.)

4. Limitations and Exclusions

a. Dental services, including extraction of teeth, except as provided for in Section III.E.3.a.(2), are not covered under this subsection.

b. Examinations and tests in connection with research studies, paternity determinations, weight control, autopsies, insurance, pre-employment or premarital examinations are not covered.

c. Services of stand-by physicians are not covered.

d. Services relating to refractive eye surgery (e.g., radial keratotomy, corneal sculpting or similar surgical procedures to correct vision) are not covered.

e. Invasive electromagnetic bone growth stimulation is not covered.

f. Growth factor treatment for wound care (e.g., Procuren) is not covered.

g. Thermography services are not covered.

h. Coverage for surgical and medical services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

F. Ambulance Service Coverage

1. Conditions of Benefit Payments

Ambulance services are covered if the following conditions and requirements are met:

a. Ambulance services must be medically necessary. Ambulance services are not medically necessary if any other means of transportation could be used without endangering the patient's health.

b. The ambulance operation providing the service must be licensed and meet Program standards.

c. A physician must prescribe the services which necessitate the use of ambulance transportation.

2. Coverages

The reasonable and customary charges for the following services are covered when furnished and billed by an eligible provider (as determined by the carrier):

a. Charges for basic life support services - a standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as basic life support services. Basic life support consists of services which provide for the initial stabilization and transport of a patient.

b. Charges for advanced life support services -- a standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as advanced life support services. Advanced life support is acute emergency treatment procedures with physician involvement.

c. Mileage charges -- a charge per mile for distances traveled while the enrollee occupies the ambulance vehicle.

d. Waiting time -- a charge for waiting time involved in round-trip transport of an enrollee from a hospital to another treatment site and return to the same hospital.

When services are received from an ambulance operation approved by the carrier, the carrier will reimburse the provider for the reasonable and customary charges as determined by the carrier. An approved provider must agree to accept, as payment in full, the carrier's determination of the amount payable for covered ambulance services.

When services are received from an otherwise eligible, but non-approved provider, the carrier will pay the enrollee the reasonable and customary charge as determined by the carrier.

3. Limitations and Exclusions

a. The following services are not covered as separate charges; such charges are included in the benefit payment for the standard charge per trip:

(1) Use of specific equipment or devices;

(2) Gases, fluids, medications, dressings, or other supplies;

(3) First aid, splinting, or any emergency medical services or personal service procedures; and

(4) Vehicle operators, attendants, or other personnel.

The charges for these services, while not covered as separate charges, are covered as a component of the charge for the basic or advanced life support services.

b. Coverage is limited to the reasonable and customary charges for transporting the patient to the nearest medical facility qualified to treat the enrollee.

c. Services of air and boat ambulance are subject to individual review.

(1) If the patient is transported to a facility other than the nearest medical facility qualified to treat the enrollee, benefits are allowed in an amount equal to that for transportation to the nearest facility.

(2) If transport by air or boat is not medically necessary, benefits are allowed in an amount equal to that for ground transportation for the same transfer.

d. Coverage does not include the following:

(1) Transportation in a vehicle not qualified as an ambulance;

(2) Transportation for enrollee, family or physician convenience;

(3) Services rendered by fire departments, rescue squads or others whose fee is in the form of a voluntary donation;

(4) Transfers not medically necessary;

(5) Fees, billed by physicians or other independent health care providers, for professional services rendered to enrollees transported by ambulance;

(6) Fees for services when the enrollee is not actually transported while under care; and

(7) Services which are payable through an existing arrangement for transfer of patients, where no additional charge is usually made, whether or not such services were immediately available.

e. Coverage for ambulance services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

G. Prescription Drug Coverage

1. Definitions

For the purposes of this subsection:

a. "brand name drug" means a drug which is covered by a patent and for which an equivalent version can not be manufactured or marketed (single source) or a drug which is no longer covered by a patent and for which chemically equivalent versions can be manufactured and marketed (multi-source). "Brand name drugs" may be either "preferred" or "non-preferred" as determined by the carrier.

b. "copayment" means an amount to be paid by the enrollee for each separate prescription order or refill of a covered drug.

c. "covered drug or supplies or diaphragm" means insulin or any prescription legend drug (except as excluded under subsection G.5. below) that is dispensed according to a prescription order, provided that:

(1) the drug or supply is medically necessary for the treatment of an illness or injury or, effective January 1, 2000, is a contraceptive medication or diaphragm;

(2) the cost of the drug is not included or includable in the cost of other services or supplies provided to the enrollee;

(3) the drug is customarily dispensed according to a prescription order; and

(4) the drug is not entirely consumed at the time and place of the prescription order.

"supplies" refers to syringes and needles dispensed with self-administered insulin or covered self-administered antineoplastic or chemotherapeutic drugs or agents under the provisions of this subsection.

"diaphragm" refers to a self-administered contraceptive device.

d. "generic drug" means a drug that is chemically equivalent to a multi-source brand name drug.

e. "nonparticipating provider" means a provider who has not entered into a contract with the carrier.

f. "participating provider" means a provider who has entered into a contract with a carrier to provide a covered drug to an enrollee, in accordance with the provisions of this Program and this subsection. Such contract shall provide for payment to the provider based on prescription charges. In the case of a preferred provider organization which provides prescription drug coverage under the Program, participating providers are the organization's panel pharmacies.

g. "pharmacist" means a person licensed to dispense prescription legend drugs under the laws of the state where such person practices.

h. "pharmacy" means a licensed establishment where prescription legend drugs are dispensed by a pharmacist.

i. "prescription charge" means a dispensing fee plus the lesser of the reasonable and customary amount paid by the provider for a covered drug (including insulin and disposable syringes and needles) or such amount as may be negotiated by the carrier with participating

providers. The "dispensing fee" is an amount or amounts, including applicable sales tax, predetermined by the carrier to compensate participating providers for dispensing covered drugs.

For covered drugs obtained from a nonparticipating provider or from a provider in an area where the carrier does not provide the coverage, the prescription charge means the reasonable and customary charge as determined by the carrier.

j. "prescription legend drug" means any medicinal substance which, under the Federal Food, Drug and Cosmetic Act, is required to be labeled "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only" and includes compounded medications containing at least one prescription legend drug.

k. "prescription order" means a written or oral request to a provider by a physician for a single prescription legend drug.

l. "provider" means a pharmacy or any other organization or person licensed to dispense prescription legend drugs.

2. Reimbursement

a. The copayment amount for each separate prescription order or refill of a covered drug shall be $5, or the prescription charge, whichever is less, for a generic drug and 25% of the prescription charge for a brand name drug, as defined in 1.a. of this subsection III.G., except that the copayment shall be:

(1) The prescription charge, if that amount is less than or equal to $15;

(2) Not less than $15, if the prescription charge exceeds that amount;

(3) Not more than $35; and

(4) $12 for generic and $40 for brand prescriptions dispensed through the Mail Order Prescription Drug program.

b. Except for the amounts indicated above, covered drugs or supplies obtained from a

participating provider are covered subject to the Program provisions.

c. Upon proof of payment acceptable to the carrier, an enrollee is entitled to reimbursement from the carrier of 75% of the reasonable and customary charge, as determined by the carrier after deduction of the copayment, of covered drugs obtained on a non-emergency basis from a nonparticipating provider located within the area in which the carrier provides coverage.

d. Upon proof of payment acceptable to the carrier, an enrollee is entitled to reimbursement from the carrier of 100% of the reasonable and customary charge, as determined by the carrier after deduction of the copayment, of covered drugs obtained from a provider located outside the area in which the carrier provides coverage or from an in-area nonparticipating provider in the case of an emergency (as determined by the carrier).

3. Coverage

a. Coverage includes up to a 34-day supply of a covered drug

b. Coverage includes an appropriate supply of disposable syringes and needles when prescribed and dispensed with a supply of self-administered insulin or a covered self-administered antineoplastic or chemotherapeutic agent.

c. Coverage includes up to a 90-day supply of covered drugs obtained through the Mail Order Prescription Drug program with a corresponding prescription or refill order. Diaphragms are not available through the mail order pharmacy.

4. Maximum Allowable Cost Programs

Maximum Allowable Cost (mandatory generic substitution) prescription drug programs or alternative generic substitution programs are applicable where in effect.

5. Prior Authorization Process

Upon the recommendation of the carrier and the approval of the Plan Administrator, certain

prescription legend drugs will require prior authorization by the carrier to be covered under the Program. Prior Authorization is a process whereby the carrier determines before the prescription legend drug is dispensed that the drug is being prescribed appropriately according to FDA approvals and the manufacturer's recommendations.

Depending on the prescription, prior authorization may be required before the initial prescription is filled or it may be required after a certain quantity of the prescription legend drug has been dispensed or the prescription legend drug has been taken for a specified period of time. The quantity or time period used to determine if and when prior authorization will be required will be recommended by the carrier, in accordance with FDA approvals and the manufacturer's recommendations, and approved by the Program Administrator.

Prescription legend drugs requiring predetermination will be covered under the Program if the Pre-determination criteria are met. A prescription legend drug requiring predetermination will not be covered under the Program if 1) the requested clinical information is not provided by either the enrollee or prescriber to the carrier, or 2) the information provided by the enrollee or prescriber to the carrier is insufficient to meet the clinical requirements determined by the carrier in accordance with FDA approvals and the manufacturer's recommendations.

The carrier will periodically make recommendations to remove or add prescription legend drugs to the prior authorization process. A list of those drugs requiring prior authorization will be made available to the enrollee by the carrier upon request.

Adverse determinations made by the carrier under the predetermination process may be appealed by the enrollee according to Article I, Section 6.

6. Limitations and Exclusions

a. Transdermal nicotine patches or any other medication or prescription legend drug used for or in connection with the control or cessation of smoking are covered only if ordered through the Mail Order Prescription Drug program.

Transdermal patches are limited to one continuous 12-week supply, lifetime maximum.

b. Coverage under this subsection does not include:

(1) any research or experimental agent including Federal Food and Drug Administration approved drugs which may be prescribed for research or experimental treatments;

(2) any charge for a prescription legend drug which requires prior authorization by the carrier for initial or continued coverage, unless such authorization is received;

(3) any charge for a medication being used for a cosmetic purpose, even if the medication is a prescription legend drug;

(4) any prescription legend drug prescribed for the purpose of attempting to induce pregnancy;

(5) any charge for a prescription legend drug prescribed for weight control or appetite suppression;

(6) any charge for devices (other than diaphragms)or appliances (e.g., orthotics, and other non-medical items);

(7) any vaccine administered for the prevention of infectious diseases;

(8) any charge for administration of covered drugs;

(9) any charge for a covered drug in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's order;

(10) any charge for more than a 34-day supply of a covered drug provided by a retail pharmacy, or any charge for more than a 90-day supply of a covered drug supplied through the Mail Order Prescription Drug program;

(11) any charge for medications furnished on an inpatient or outpatient basis covered under any other subsection of this Appendix or under any subsection of Appendix B; and

(12) any charge for drugs received prior to the effective date of this coverage.

c. Certain prescription legend drugs are covered at retail, at the applicable 34-day copayment, for an original prescription and two (2) refills; thereafter, they are covered at mail, at the applicable 90-day copayment or at retail subject to a 100% copayment penalty.

The carrier will periodically make recommendations to remove or add prescription legend drugs that are subject to this restriction. A list of those drugs requiring prior authorization will be made available to the enrollee by the carrier upon request.

d. Coverage under this subsection is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

7. Pharmacy Network

a. The carrier will maintain a nationwide limited network of participating retail providers (including local and national pharmacy chains, as appropriate), and a mail order pharmacy. The carrier will select network pharmacies, in part, on access and quality assurance criteria. In contracting with providers, the carrier will assure that the providers fully understand the Program's prescription drug coverage provisions, including eligibility requirements and benefit levels. The carrier will negotiate appropriate fees with participating providers.

b. The carrier will meet standards of quality, service and accessibility (e.g., availability of participating providers within 5 miles of enrollee's residence or closest facility if greater than 5 miles for 90% of enrollees).

c. The carrier will establish uniform pharmacy protocols, pharmacy auditing procedures, drug utilization review processes and all quality assurance procedures.

d. The carrier will monitor network performance and provide aggregate data on a regular basis. Data reports will include, but not be limited to, information such as utilization of services, costs, quality measurements, use of various categories of drugs (e.g., generic, single source, etc.), provider prescribing patterns and patient outcomes.

e. The carrier will be subject to independent audits to assure that quality, service, professional standards and other express commitments are being met.

f. The carrier will make benefit payments to the participating providers or, in the case of services received from non-participating providers, the carrier will make benefit payments to the enrollee or non-participating provider, as appropriate.

g. The carrier will administer Drug Utilization Review (DUR) activities to review whether patients receive appropriate drug therapy as measured against generally accepted pharmaceutical practices. Such DUR incorporates concurrent and retrospective reviews. It also incorporates a voluntary drug formulary and a mandatory program to promote use of generic prescription drugs, where appropriate. In addition, DUR will attempt to identify a variety of critical drug therapy problems such as, but not limited to:

(1) Drug-disease conflicts;
(2) Drug-drug interactions;
(3) Age/gender prescription conflicts;
(4) Over and under utilization;
(5) Allergy alerts;
(6) Therapeutic duplication; and
(7) Early refills.

h. The carrier will provide a comprehensive on-line, point-of-service claims processing system with an electronic telecommunication network that facilitates management of enrollee eligibility verification, formulary information, drug prescribing protocols, drug utilization review, pharmacy reimbursement and possibly expanded patient information, to make informed dispensed decisions.

i. The carrier will conduct pharmacist profiling, and individual intensive education will be completed as necessary.

j. The carrier will conduct physician profiling and will identify physicians who exhibit persistently inappropriate prescribing patterns across their practice. Such physicians will be subject to individual intensive education efforts, as necessary.

k. The carrier will prepare appropriate communications regarding the prescription drug coverage for enrollees, network pharmacies and, as necessary, for prescribing physicians.

l. The carrier will ensure that quality assurance mechanisms will be administered to identify routinely inappropriate drug prescribing that could result in adverse medical outcomes, including hospitalization, by incorporating components such as:
(1) A total quality management (TQM) philosophy;
(2) Rigorous pharmacy management and performance monitoring;
(3) Prescribing physician reeducation, as necessary;
(4) Client specific program performance management;
(5) Patient medication compliance monitoring; and
(6) Outcomes assessment analyses.

H. Hearing Aid Coverage

1. Definitions

For the purposes of this subsection:

a. "physician" means a participating otologist or otolaryngologist who is board certified or eligible for certification in such specialty in compliance with standards established by the respective professional sanctioning body, who is a licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of such license, performs a medical examination of the ear and determines whether the patient has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid;

b. "audiologist" means any participating person who (1) possesses a master's or doctorate degree in audiology or speech pathology from an accredited university, (2) possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and (3) is qualified in the state in which the service is provided to conduct an audiometric examination and hearing aid evaluation test for the purposes of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the enrollee's loss of hearing acuity. A physician performing the foregoing services shall be deemed an audiologist for purposes of this subsection;

c. "dealer" means any participating person or organization that sells hearing aids prescribed by a physician or audiologist to improve hearing acuity in compliance with the laws or regulations governing such sales, if any, of the state in which the hearing aids are sold;

d. "provider" means a physician, audiologist or dealer;

e. "participating" means having a written agreement with the carrier pursuant to which services or supplies are provided under this subsection (if the carrier does not maintain agreements with such providers, "participating" shall mean any provider approved for reimbursement by the carrier);

f. "hearing aid" means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if necessary;

g. "ear mold" means a device of soft rubber, plastic or a non-allergenic material which may be vented or nonvented that individually is fitted to the external auditory canal and pinna of the enrollee;

h. "audiometric examination" means a procedure for measuring hearing acuity that includes tests relating to air conduction, bone conduction, speech reception threshold and speech discrimination;

i. "hearing aid evaluation test" means a series of subjective and objective tests by which a physician or audiologist determines which make and model of hearing aid will best compensate for the enrollee's loss of hearing acuity and which make and model will therefore be prescribed, and shall include one visit by the enrollee subsequent to obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription;

j. "dispensing fee" means a fee predetermined by the carrier to be paid to a dealer for dispensing hearing aids, including the cost of providing ear molds, under this subsection;

k. "acquisition cost" means the actual cost to the dealer of the hearing aid.

2. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered hearing aid expenses subject to the provisions below.

a. Charges incurred for audiometric examinations are covered to the extent that these charges are reasonable and customary when performed by a physician or audiologist, but only in conjunction with the most recent medical examination of the ear by a physician.

b. Hearing aid evaluation tests are covered only when indicated by the most recent covered audiometric examination up to $12 ($126 effective October 1, 2004) per test or, if higher, the adjusted maximum determined under subsection e. below.

Hearing aid evaluations performed by a physician or audiologist include the trial and testing of various makes and models of hearing aids to determine which one will best compensate for the loss of hearing acuity.

c. Standard hearing aids are covered if:

(1) they are of the following functional design: in-the-ear, behind-the-ear (including air conduction and bone conduction types) or on-the-body;

(2) they are prescribed based upon the most recent audiometric examination and most recent hearing aid evaluation; and

(3) the hearing aid provided by the dealer is the make and model prescribed by the physician or audiologist and is certified as such by the physician or audiologist. Binaural hearing aids will be provided only for children under 19 years of age with a hearing loss in both ears. For children 7 years of age and under, replacement ear molds are covered as of January 1, 2004 for:

(a) 4 ear molds per year for children under the age of 3; and

(b) 2 ear molds per year for children ages 3 through 7.

d. In order for the charges for services and supplies described in b. and c. immediately above to be covered under this subsection, for an initial hearing aid, an enrollee must first obtain a medical examination of the ear by a physician. Such examination or such examination in conjunction with the audiometric examination must result in a determination that a hearing aid would compensate for the loss of hearing acuity and, in the case of binaural hearing aids for children, would correct or prevent speech impairment. For enrollees under the age of 18, a medical exam is required each time a hearing aid is covered.

e. The maximum covered expense for a hearing aid evaluation test shall be adjusted on October 1 of each year, based on the percentage increase as of the July levels in the United States Consumer Price Index for the immediately preceding 12 months. The result will be rounded to the nearest dollar.

3. Coverages

The enrollee may obtain audiometric examinations, hearing aid evaluation tests and hearing aids that the provider shall have agreed to furnish enrollees in accordance with the following reimbursement arrangements:

a. for an audiometric examination, the reasonable and customary charge;

b. for hearing aid evaluation tests, the reasonable and customary charge, but not to exceed the amount as provided in subsections H.2.b. and e.; and

c. for covered hearing aids, the acquisition cost and dispensing fee.

If the enrollee requests services or devices from the provider which are not covered under these provisions (e.g., binaural hearing aids for enrollees over 19), the enrollee shall pay the full additional charge.

4. Frequency Limitations

If an enrollee has received an audiometric examination, a hearing aid evaluation test or a hearing aid for which benefits were payable under this subsection, benefits will be payable for each subsequent audiometric examination, hearing aid evaluation test or hearing aid only if received more than 36 months after receipt of the most recent previous audiometric examination, hearing aid evaluation test and hearing aid, respectively, for which benefits were payable under this subsection.

5. Exclusions

Covered hearing aid expenses do not include and no benefits are payable under this Section III.H., for:

a. audiometric examinations by an audiologist for any condition other than loss of hearing acuity;

b. medical or surgical treatment;

c. drugs or other medication;

d. audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable Worker's Compensation law;

e. audiometric examinations and hearing aid evaluation tests performed, and hearing aids ordered:

(1) before the enrollee became eligible for coverage; or

(2) after termination of the enrollee's coverage;

f. hearing aids ordered while covered but delivered more than 60 days after termination of coverage;

g. audiometric examinations, hearing aid evaluation tests and hearing aids for which no charge is made to the enrollee or for which no charge would be made in the absence of hearing aid coverage;

h. audiometric examinations, hearing aid evaluation tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the physician;

i. audiometric examinations, hearing aid evaluation tests and hearing aids that do not meet professionally accepted standards of practice, including any such services or supplies that are experimental in nature;

j. audiometric examinations, hearing aid evaluation tests and hearing aids received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;

k. audiometric examinations, hearing aid evaluation tests and hearing aids provided by any governmental agency that are obtained by the enrollee without cost by compliance with laws or regulations enacted by any Federal, state, municipal or other governmental body;

l. audiometric examinations, hearing aid evaluation tests and hearing aids to the extent benefits therefor are payable under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision thereof;

m. replacement of hearing aids that are lost or broken unless at the time of such replacement

the enrollee is otherwise eligible under the frequency limitations set forth herein;

n. replacement parts for and repairs of hearing aids;

o. charges incurred by enrollees of a health maintenance organization option;

p. charges for a eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one standard, conventional hearing aid (See Subsection H.2.c., above);

q. binaural hearing aids except as provided in this subsection for children under 19 years of age; and

r. charges for a digital-controlled/programmable hearing devices, to the extent the charge for such hearing device exceeds the covered expense for a standard, conventional hearing aid (See Subsection H.2.c., above).

I. Durable Medical Equipment and Prosthetic and Orthotic Appliance Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for the rental or purchase of durable medical equipment and the purchase of prosthetic and orthotic appliances only when the following conditions have been met:

a. the items rented or purchased are basic equipment or appliances or are medically necessary special features which are prescribed by the attending physician and approved by the carrier;

b. the equipment or appliances are prescribed by a physician and the prescription includes a description of the equipment and the reason for use or the diagnosis;

c. for purchased durable medical equipment or prosthetic or orthotic appliances, the order must be placed on or after the effective date and prior to the termination date of the enrollee's coverage in this Program; and

d. for rented durable medical equipment, the rental period is on or after the effective date and prior to the termination date of the enrollee's coverage in this Program.

2. Payment of Services

a. The carrier will make payment for the reasonable and customary charge for rental or purchase of durable medical equipment when obtained from a provider other than a hospital or skilled nursing facility. Benefit payments for rental of durable medical equipment shall not exceed the purchase price of such equipment.

b. The carrier will make payment for the reasonable and customary charge for external prostheses and orthotic appliances.

c. Effective January 1, 1998, a nationwide network was established for the administration of coverages for durable medical equipment and prosthetic and orthotic appliances. No enrollee deductible or copayment is required for covered services received within the national network. For services received outside the network, the enrollee is responsible for any difference between the provider's charge and the reasonable and customary charge.

3. Coverages

a. Process for Updating Coverages

(1) A procedure has been established for the ongoing periodic update of the durable medical equipment and prosthetic and orthotic appliance coverages.

(2) Written notification of changes in Medicare Part B durable medical equipment and prosthetic and orthotic appliance coverages, and other recommendations for coverage changes, will be provided to the Corporation by the Control Plan.

The notifications and recommendations shall include, but not be limited to, the following information:

(a) Quality of care, access and appropriate utilization concerns and proposed actions to resolve such concerns;

(b) Any item(s) being replaced by new item(s), and a plan for discontinuation of coverage for the replaced item(s); and

(c) Positive or negative impact on Program costs.

(3) The Corporation shall review and approve or disapprove the application of Medicare Part B coverage changes or other Control Plan recommendations. If approval is given for a coverage change, an effective date will be established.

(4) The Control Plan will advise appropriate carriers of any changes that are approved through this procedure, the effective dates, and any applicable administrative rules. The local carriers will advise providers.

b. Durable Medical Equipment

(1) Unless otherwise indicated below, the equipment must be an item of durable medical equipment, which meets Program standards including being approved for reimbursement under Medicare Part B or adopted in accordance with the process in subsection 3.a., above, and be appropriate for use in the home.

(2) Durable medical equipment is covered when used in a hospital or skilled nursing facility, or when used outside the hospital or skilled nursing facility and rented or purchased from such hospital or facility upon discharge.

(3) When the equipment is rented and the rental period extends beyond the expiration of the original prescription, the physician must recertify, by another prescription, that the equipment continues to be reasonable and medically necessary for the treatment of the illness or injury or to improve the

functioning of a malformed body member. If the recertification is not submitted, coverage will cease on the date indicated on the original prescription for duration of need, or 30 days after the date of death, whichever is earlier. Coverage will not be provided for rental charges in excess of the purchase price of the equipment.

(4) When the equipment is purchased, coverage is provided for repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance is not covered.

(5) The following equipment is covered, subject to any stated conditions and to the other Program standards, although not Medicare approved:

(a) neuromuscular stimulators, if prescribed by an orthopedic or physiatric specialist;

(b) positioning transportation chairs as alternatives to traditional wheelchairs for children 14 years of age and under, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders or congenital abnormalities;

(c) external electromagnetic bone growth stimulators, as an alternative to bone grafting in cases of severe physical trauma involving non-union of long bone fractures (in excess of 90 days from the date of fracture), or failed bone fusion (stimulators employed in invasive stimulation are excluded under this subsection I.);

(d) pressure gradient supports (also known as burn pressure garments) prescribed for circulatory insufficiency conditions to promote and restore normal fluid circulation in the extremity (up to four times annually for chronic

conditions unless there is a change in physical conditions such as gain or loss of weight of the patient), or when prescribed to enhance healing and prevent scarring of burn patients;

(e) phototherapy (bilirubin) light with photometer, for patients under the age of one having a diagnosis of hyperbilirubinemia;

(f) special features which, although not subject to review and approval under Medicare Part B, are necessary to adapt otherwise covered equipment for use by children; and

(g) continuous passive motion device for use after surgery to the elbow or shoulder (as well as following total knee replacement, as provided by Medicare).

(6) Pronged and standard canes must be purchased.

c. Prosthetic and Orthotic Appliances

(1) Unless otherwise indicated below, the appliance must be a prosthetic or orthotic device which meets Program standards, including being approved for reimbursement under Medicare Part B or adopted in accordance with the process in subsection 3.a., above.

(a) Coverage for therapeutic shoes prescribed for diabetic enrollees not eligible for Medicare shall be limited to the diagnoses established by the Control Plan.

(b) The following items are covered, subject to any stated conditions and to other provisions of the Program and this subsection, although not Medicare-approved:

(i) any style of orthopedic shoe, in addition to a basic oxford,

when the shoe is an integral part of a covered brace;

(ii) all orthopedic shoe inserts, arch supports and shoe modifications used with a shoe that is attached to a covered brace; and

(iii) wigs and appropriate related supplies (stands and tape) are covered for those enrollees suffering hair loss from the effects of chemotherapy, radiation, or other treatments for cancer. For the first purchase of a wig and necessary related supplies coverage will be provided up to $200. Thereafter, during each subsequent calendar year, coverage will be provided up to $125 towards the purchase of a wig and necessary related supplies.

(2) Coverage is provided for appliances furnished by a fully accredited facility or, with carrier approval, by facilities conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. as a provider for the kind of device supplied. The following appliances may be provided by facilities not accredited by the American Board for Certification in Orthotics and Prosthetics: ocular prostheses; prescription lenses; pacemakers; ostomy sets and accessories; catheterization equipment and urinary sets; prefabricated custom fitted orthotic appliances; artificial ears, noses, and larynxes; external breast prostheses; wigs and related supplies and such other appliances as the carrier may determine.

(3) Coverage includes prosthetic appliances or devices which are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital

equipment, as well as external prosthetic or orthotic appliances prescribed by a physician for use outside the hospital.

(4) Coverage for a prosthetic and orthotic appliance includes the replacement, repair, fitting and adjustments of the appliance.

(5) Coverage includes only the first set of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence, or when customarily used during convalescence from eye surgery.

4. Limitations and Exclusions

a. Durable medical equipment which is not covered includes, but is not limited to:

(1) deluxe equipment such as motor driven wheelchairs and beds, unless medically necessary for the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment (for deluxe equipment or features which are not medically necessary for the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment, benefits are limited to the comparable cost of basic, standard equipment);

(2) comfort, convenience, self-help and environmental items not primarily medical in nature such as, but not limited to, bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms, air conditioners, humidifiers, sauna baths, paging systems, intercoms and elevators;

(3) physician's equipment (such as sphygmomanometers and stethoscopes);

(4) exercise and hygienic equipment (such as exercycles, Moore Wheel, bidet, toilet seats and bathtub seats);

(5) experimental, investigational or research equipment; and

(6) home uterine monitoring equipment.

b. Coverage for prosthetic and orthotic appliances does not include:

(1) dental appliances; hearing aids; eyeglasses (except as provided in subsection 3.b.(5) above); or such non-rigid appliances and supplies as elastic stockings, garter belts, corsets or arch supports and corrective footwear unless the footwear is attached to a medically necessary brace and covered under subsection 3.b.(1), above;

(2) foot orthotics or any device used to protect the foot from trauma caused by gravitational forces or shoe pressure, whether functional, supportive, accommodative or digital in nature, and whether or not custom-molded;

(3) hair pieces or wigs, except as specified in Section III.I.3.c.(1)(b)(iii); or

(4) experimental, investigational or research devices.

J. Hospice Coverage

Hospice coverage, as described below, is available to Basic Medical Plan, Enhanced Medical Plan, Standard Medical Plan, Standard Plus Medical Plan and Point-of-Service option enrollees. It addresses the needs of terminally ill patients who do not require the continuous level of care provided in a hospital or skilled nursing facility.

1. Definitions

For the purposes of this subsection:

a. "Bereavement counseling" means services provided to the patient's family (or other person caring for the patient at home) after the patient's death.

b. "Care rendered in a nursing home facility with hospice support" means care provided to

patients who are medically stable but unable to return home because there is no primary care giver available to care for the patient at home, and the patient cannot self-administer the needed care.

c. "Respite care" means short-term inpatient care provided only when necessary to give relief to family members or other persons caring for the patient at home.

2. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered expenses incurred in a hospice program only if the following conditions have been met:

a. The hospice program services are received on or after the effective date and prior to the termination date of the enrollee's coverage in this Program.

b. The services are provided and billed by a hospice program which meets Program standards and is approved by the local carrier.

c. The enrollee is admitted to the hospice program by order of a physician who certifies that the enrollee requires the type of care available through the hospice and that the enrollee has a life expectancy of six months or less.

d. The enrollee voluntarily elects to participate in the hospice program and agrees to accept the services provided by the hospice program as treatment of the terminal condition.

e. The enrollee has benefit period days available under the hospice benefit period (see App. A, II.B.).

3. Coverages

a. Benefits for hospice services are limited to a maximum aggregate lifetime benefit in accordance with Program standards.

b. Upon admission to an approved hospice program, an enrollee is entitled to receive the following services when rendered as part of the treatment plan:

(1) nursing care provided by or under the supervision of a registered nurse;

(2) medical social services provided by a social worker under the direction of a physician;

(3) physician services;

(4) counseling services provided to the patient, family members and/or other persons caring for the patient at home;

(5) general inpatient care provided in a hospice inpatient unit;

(6) medical appliances and supplies;

(7) physical, occupational and speech therapies;

(8) continuous home care provided during periods of crisis as necessary to maintain the patient at home;

(9) respite care;

(10) bereavement counseling;

(11) care rendered in a nursing home with hospice support; and

(12) home health aide services.

K. Case Management Program

1. Case Management (CM) is a component which is applicable to Basic Medical Plan, Enhanced Medical Plan, Standard Medical Plan, Standard Plus Medical Plan, and POS Plan option enrollees, and which is intended to provide high quality, cost-effective alternative treatment options for patients with catastrophic, chronic, and long-term treatment needs which may result in exhaustion of benefits or high costs. It focuses on those whose care could be maintained, improved or prolonged by more effective use of existing Program provisions or, in appropriate cases, through Alternative Benefit Plans designed to cost no more than the treatment otherwise planned. The Case Management Program is not a method for approving new procedures or services not otherwise covered under the Program.

2. The list of conditions used by the carriers or Utilization Review Organization, as appropriate, for review for potential CM involvement includes, but is not limited to, the following:

   a. major head trauma;

   b. spinal cord injury;

   c. coma;

   d. multiple amputations;

   e. traumatic and degenerative muscular/neurological disorders (e.g., muscular dystrophy, "Lou Gehrig's Disease," multiple sclerosis);

   f. newborns with high risk complications;

   g. births with multiple congenital anomalies;

   h. cerebrovascular accident (stroke) requiring long-term rehabilitation;

   i. severe burns;

   j. Acquired Immune Deficiency Syndrome (AIDS);

   k. selected blood abnormalities;

   l. diagnoses involving long-term IV therapy (e.g., osteomyelitis, pericarditis, endocarditis);

   m. severe rheumatoid arthritis;

   n. selected osteoarthritis;

   o. Crohn's disease; and

   p. cases involving extended or repeated hospital stays, as well as cases having multiple admissions for the same diagnosis.

3. Once a patient's medical condition is identified by the carrier or Utilization Review Organization, as appropriate, as having potential for Case Management, the case is reviewed confidentially, and a treatment plan may be developed by the carrier or Utilization Review Organization, as appropriate, with the cooperation of the patient, family, and the physicians/providers.

4. If a decision is made to implement a treatment plan that incorporates services not otherwise covered under this Program (an Alternative Benefit Plan), the remaining days of inpatient care, determined in accordance with the attending physician's prognosis, are converted into a dollar pool against which all benefits paid while the patient is under the Alternative Benefit Plan are charged.

   a. The total cost of Alternative Benefit Plans involving services not otherwise covered will be limited by the cost of treatment which would have occurred otherwise.

   b. If the dollar pool is exhausted, the Alternative Benefit Plan ceases and the provisions of Appendix A, II.B. will apply with regard to renewal of a benefit period.

   c. Participation in Case Management is voluntary, and the patient may withdraw from an Alternative Benefit Plan at any time. In such event, the remaining dollar pool is reconverted to equivalent hospital days to determine the patient's entitlement, if any, remaining in the benefit period.

L. Centers of Excellence

1. Centers of Excellence Program (COE) is a voluntary component applicable to Basic Medical Plan and Enhanced Medical Plan option enrollees who do not have Medicare or another group health care plan as their primary coverage. COE is intended to provide information on and access to high quality facilities which specialize in certain organ transplant, cardiac and cancer procedures. It focuses on certain procedures which have been demonstrated to result in better clinical outcomes when performed in higher volume Centers of Excellence facilities. COE is not a method for approving new procedures or services not otherwise covered under the Program.

2. The organ transplant, cardiac and cancer procedures included in COE will be determined based on their clinical complexity by the Utilization Review Organization. The organ transplant, cardiac and cancer procedures may be updated periodically by the Utilization Review Organization, as appropriate.

3. During the predetermination review of a COE procedure, the Utilization Review Organization will evaluate the case for COE referral. The Utilization Review Organization will consider the patient's medical condition, and the clinical complexity of the COE procedure to make COE referrals as they deem appropriate. Participation in COE is voluntary.

4. If the enrollee is offered and agrees to participate in the COE for covered services, additional coverage may be provided for related travel, meal and lodging expenses of the patient and one caregiver, up to a lifetime maximum of $7,500 per enrollee per condition, in accordance with the following requirements:

   a. The enrollee is referred to a COE facility located more than 100 miles from the enrollee's place of residence;

   b. Paid receipts and other documentation are provided by the enrollee as required by the Utilization Review Organization; and

   c. The reimbursement of travel, meal and lodging expenses is approved by the Utilization Review Organization.

5. If an enrollee is referred to a COE facility which is not a participating facility with their Basic Medical Plan or Enhanced Medical Plan, the facility will be treated as a participating facility for COE services provided.

6. In the Point of Service Plan, coverage for organ transplants is only available through network providers.

M. Disease Management

1. Disease Management (DM) is a voluntary component which is applicable to Basic Medical Plan, Enhanced Medical Plan and Point of Service plan option enrollees who do not have Medicare or another group health care plan as their primary coverage. DM is intended to provide education and support for enrollees with asthma, diabetes and cardiac conditions. It focuses on assisting enrollees to better manage their condition. Disease Management is not a method for approving new procedures or services not otherwise covered under the Program.

2. Except for the Point of Service Plan, if an enrollee is offered and agrees to participate in DM, coverage may be provided for patient education and related services not otherwise covered under this Program in accordance with the following conditions:

   a. The services are approved in advance by the carrier or Utilization Review Organization, as appropriate.

   b. The services are part of a disease management treatment plan and are focused on the enrollee's asthma, diabetes or cardiac condition.

IV. Limitations and Exclusions

In addition to the limitations and exclusions appearing in other Sections of this Appendix, the following general limitations and exclusions apply to all Sections:

A. Effective date: For the purposes of this Section, effective date means the later of the effective date of this Program or the effective date of the enrollee's coverage under this Program. Benefits are not provided under this Program for:

   1. services, treatment, or care provided to an enrollee prior to the effective date; or

   2. hospital, skilled nursing facility, or home health care services for admissions which commenced prior to the effective date.

B. Termination date: Coverage is not provided for services provided after the date this Program or an enrollee's coverage under this Program is terminated except that the coverage continues for physician and hospital, skilled nursing facility, or residential substance abuse facility services for continuous predetermined and approved (see App. A, II.A. and App. B, II.A.) inpatient admissions which commenced prior to the termination date of such coverage.

C. Excluded facilities: Coverage under this Appendix does not include services provided by a day or night care program, a halfway house, group home, adult foster care facility, health club or the like.

D. Private duty nursing services: Coverage under this Appendix does not include services of private duty nurses.

E. Room accommodations: If accommodations more expensive than those specified in Section III.A. are used for any reason, the carrier will not pay the difference between the charges for the more expensive accommodations and those for the covered accommodations. If, for any reason, the enrollee occupies accommodations less expensive than those covered by this Appendix, the enrollee is not entitled to payment of the difference in charges.

F. Dental services: Coverage does not include dental services except as specifically provided for in this Appendix.

G. Temporomandibular joint (TMJ) dysfunction: Coverage under this Appendix for diagnosis and treatment of TMJ dysfunction is limited to diagnostic examinations and imaging, surgery to the joint (including related facility charges) and medically necessary post-surgical physical therapy services.

H. Chemotherapy: Coverage does not include chemotherapy services or supplies (chemotherapeutic antineoplastic agents and their administration) when the treatment is research, investigational or experimental in nature or when not specifically provided for in this Appendix.

I. Medical necessity: Coverage does not include services, care, treatment, or supplies which are not medically necessary according to accepted standards of medical practice in the United States for the diagnosis and/or treatment of any condition, injury, disease, or pregnancy, except as specifically provided for in this Appendix (e.g., physical examinations, immunizations, screening tests, contraceptive services and voluntary sterilization's, see App. A.I.R.). Determinations of the Control Plan or Utilization Review Organization, as appropriate, as to medical necessity and the accepted standards of medical practice are based on factors which include, but are not limited to: scientific data (such as reported controlled studies); information from local and national medical, professional and insurance societies, organizations, committees and bodies; and approvals and policies of the Food and Drug Administration, the Department of Health and Human Services and other Federal agencies. The Control Plan or Utilization Review Organization, as appropriate, shall have discretionary authority to interpret, apply and construe this provision of the Program. Their exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator

to have been inconsistent with the Program provisions or arbitrary and capricious.

J. Research, investigational or experimental services: Coverage does not include care, services, supplies, or devices ("procedures") which, as determined by the Control Plan, are experimental, research or investigational in nature (i.e., ones, which in the judgment of the Control Plan, have not been demonstrated scientifically to be both effective and safe in the treatment of the patient's condition). This exclusion applies to facility and professional services directly related to non-covered experimental, research or investigational procedures. However, if the Control Plan or Utilization Review Organization, as appropriate, determines that hospitalization is medically necessary and appropriate in order for such non-covered procedure to be performed safely, routine hospital and professional services not related directly to such non-covered procedure may be covered. The Control Plan is responsible for determining whether a procedure is experimental, research or investigational in nature based on factors which include, but are not limited to: the existence of an experimental, research or investigational plan or protocol; the necessity for written informed consent used by the treating physician (which may or may not include a reference to the procedure being research, investigational, experimental or other than conventional in nature); existence of ongoing clinical trials; scientific data such as controlled studies which are reported in medical literature; approvals and policies of Federal agencies; and information from professional groups. The Control Plan shall have discretionary authority to interpret, construe and apply this provision of the Program. The Control Plan's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious. (See Article I, Section 6 (b) for appeal of a determination that a service, supply device or drug therapy is research, experimental, or investigational in nature.)

Procedures, services, supplies, drugs, products, applications of the above and other items which are considered to be experimental, research or investigational are evolutionary in nature. The Control Plan is responsible for maintaining current information on items which have been so identified for purposes of claims adjudication, and such information is incorporated herein by reference.

The fact that a procedure, service, supply, drug, product, etc., is not so identified shall not in any way infer that it is not experimental, research or investigational in nature. The information is intended to be illustrative rather than exhaustive.

Enrollees and/or providers having questions about the status of items may obtain Control Plan assistance in resolving the questions.

At the point in time when the Control Plan determines a procedure previously identified as experimental, research or investigational has become standard medically accepted practice in the United States, the Control Plan will make a recommendation to the Corporation under the procedure for approval of new services (see App. A, II.I.). If the Control Plan's recommendation is adopted (in its entirety or with modifications), an effective date will be assigned and coverage will be provided on and after that date. If the Control Plan's recommendation is rejected, the procedure will be identified as a specific Program exclusion.

K. Personal or convenience items: Coverage does not include care, services, supplies, or devices which are personal or convenience items. Examples include, but are not limited to, television/telephone rental, guest meals and the like.

L. Services not related to specific diagnosed illness or injury: Coverage does not include services for premarital examinations or pre-employment examinations.

M. Unreasonable charges: Coverage does not include any charges to the extent such charges are determined by the carrier to be unreasonable.

N. Employer related services: Coverage does not include services related to any condition, disease, ailment, or injury arising out of or in the course of employment and for which the employer furnishes, pays for, or provides reimbursement under the provisions of any law of the United States or any state or political subdivision thereof, or for which the employer makes a settlement payment. Coverage does not include services rendered through a medical clinic or other similar facility provided or maintained by an employer.

O. Services available without cost: Coverage does not include services for which a charge would not have been made if no coverage existed; services for which the enrollee is not legally obligated to pay; or services

which the enrollee received or, upon application, could receive without cost under the laws or regulations of the United States of America, Dominion of Canada, any other country, or any state or political subdivision thereof.

P. Services available through other programs: Coverage does not include any service to the extent the benefits are payable:

1. Under any group health care contract under the coordination of benefits provision of this Program;

2. Under Medicare, if the enrollee was or would have been eligible for Medicare benefits at the time of service had the enrollee enrolled in Medicare (see App. A, II.E.); or

3. Under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision except where by law this Program is made primary.

Q. Services provided by family members or relatives: Coverage does not include services provided to the enrollee by members of the enrollee's household or immediate relatives of the enrollee. For purposes of this provision, "immediate relative" refers to the enrollee's spouse, natural or adoptive parents, children or siblings, step-parents, -children or -siblings, father-, mother-, son-, daughter-, brother- or sister-in-law, and grandparents or grandchildren of the enrollee or the enrollee's spouse.

R. Custodial or domiciliary care: Coverage does not include care, services, supplies or devices related to custodial or domiciliary care provided in an institutional setting (e.g., hospital, nursing facility) except as provided under the home health care and hospice provisions of this Appendix (App. A, III.D. and III.J., respectively).

S. Inducement of pregnancy: Coverage does not include care, services, supplies, drugs or devices which are provided for the purpose of inducing pregnancy.

T. Travel: Coverage does not include travel time or expenses.

U. Education: Coverage does not include special education facilities and tutoring for learning disabilities or correction of behavioral problems.

V. Food and dietary supplements: Coverage does not include food/dietary supplements or vitamins.

W. Physician requirements: Coverage does not include services, supplies or equipment not performed by, prescribed by or rendered by a physician.

X. Miscellaneous services: Coverage does not include charges for acupuncture, massage, Christian Science services, hypnotherapy, neurotherapy, or biofeedback therapy or services.

Y. Provider administrative charges: Coverage does not include charges for missed appointments, room or facility reservations or the completion of any claim forms or record processing.

Z. Bone marrow transplants:

1. Allogeneic bone marrow harvesting/transplants

a. Facility and physician services are covered when related to allogeneic bone marrow harvesting and transplants performed to treat the following conditions:

(1) aplastic anemia;

(2) acute lymphocytic and non-lymphocytic leukemia;

(3) chronic myeloid leukemia;

(4) severe combined immune deficiency disease (SCID);

(5) Wiskott-Aldrich syndrome;

(6) osteopetrosis;

(7) beta thalassemia, major;

(8) neuroblastoma (stage III or IV);

(9) Hodgkin's disease (stage III or IV);

(10) non-Hodgkin's lymphoma (intermediate or high grade);

(11) Hurler's syndrome; and

(12) myelodysplastic syndromes.

(13) breast cancer (stage IV);

(14) sickle cell anemia for selected patients;

(15) myelofibrosis;

(16) hematologic malignancies; and

(17) non-malignant bone marrow disorders.

b. Bone marrow transplants are covered when the donor is a first degree relative and has either the same genetic (i.e., human leukocyte antigen or HLA) markers (six out of the six important genetic markers) or at least four out of the six important genetic markers as the person receiving the transplant. When only four or five out of the six genetic markers match, the mixed lymphocyte culture (MLC) must be negative.

c. Also included as covered services are:

(1) bone marrow transplants when the donor is not a first degree relative and has the same five important genetic markers as the person receiving the transplant;

(2) blood tests on relatives for evaluation as donors, if the tests are not covered by the potential donor's health care coverage;

(3) harvesting of marrow, if not covered by the donor's health care coverage, when the donor is:

(a) a first degree relative with no less than four out of the six important genetic markers as the person receiving the transplant; or

(b) a person other than a first degree relative with the same five out of six important genetic markers as the person receiving the transplant;

(4) search of the National Donor Marrow Program Registry for a donor, and harvesting and transportation of marrow, when the donor is:

(a) a first degree relative with no less than four out of the six important genetic markers as the person receiving the transplant; or

(b) a person other than a first degree relative with the same five out of six important genetic markers as the person receiving the transplant;

provided the Registry's bill must be submitted to the carrier by the bone marrow transplant center.

2. Autologous bone marrow/peripheral stem cell harvesting/transplants

Facility and physician services are covered when related to autologous bone marrow/peripheral stem cell harvesting and transplants performed for the following conditions:

a. Hodgkin's disease (stage III or IV);

b. non-Hodgkin's lymphoma (intermediate or high grade);

c. neuroblastoma (stage III or IV);

d. acute lymphocytic and non-lymphocytic leukemia;

e. germ cell tumors of ovary, testis, mediastinum or retroperitoneum

f. multiple myeloma; and

g. AL amyloidosis.

3. Non-covered expenses

Facility and physician services and other charges directly relating to bone marrow transplants other than those identified in subsections Z.1. and Z.2., above, are excluded. Excluded services and charges include, but are not limited to:

a. bone marrow transplants when the donor is a first degree relative and has less than five out of six genetic markers as the person receiving the transplant;

b. bone marrow transplants when the donor is not a first degree relative and has less than six out of six genetic markers as the person receiving the transplant;

c. autologous bone marrow and/or peripheral stem cell and/or allogeneic bone marrow harvest and transplants for solid tumors other than shown in 1. and 2. above;

d. allogeneic bone marrow transplants for patients with multiple myeloma;

e. search of the National Donor Marrow Program Registry for a donor, other than a first degree relative, with fewer than five out of six important genetic markers as the person receiving the transplant;

f. bone marrow harvesting, storage, transportation or transplantation from a person, other than a first degree relative, with fewer than five out of six important genetic markers as the person receiving the transplant;

g. purging or positive stem cell selection of the bone marrow or peripheral stem cell collection; and

h. travel expenses of patients (other than ambulance services which may be covered under App. A, III.F., in appropriate cases) and family members.

AA. Cochlear implant: Coverage under this Appendix, for services related to the implantation of a cochlear hearing device, is subject to Program standards regarding patient selection, covered pre-surgical, surgical and post-surgical services and covered devices, as well as to a lifetime maximum of one device/implantation for each enrollee satisfying the patient selection criteria.

BB. Services related to corrective eye surgery: Coverage under this Appendix does not include any services, supplies or charges related to corrective eye surgery, as defined in Appendix D, III.K. of this Program. See Appendix D, IV. C. for Program coverage provisions for such surgery.

APPENDIX B

MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE

The provisions of this Appendix B apply to enrollees of the Comprehensive Health Savings Plan (CHSP),Basic Medical Plan, Enhanced Medical Plan, and Point of Service options of the Program.

I. Definitions

To the extent they are not in conflict with the following, definitions in Appendix A are incorporated herein by reference. For purposes of this Appendix:

A. "approved mental health or substance abuse treatment program and/or provider" means an inpatient or outpatient program and/or provider which/who provides medical and other services to enrollees for a mental health or substance abuse condition, meets all state licensure and approval requirements, and has entered into an agreement with the coverage carrier to provide services as specified in this Appendix.

B. "assessment" means

1. determination by an assessment coordinator of the nature of the enrollee's condition (mental health and/or substance abuse), the need for treatment, the type of treatment required and referral to the most appropriate level of care; and

2. for a substance abuse patient, the development of a continuing care treatment plan by the enrollee, the assessment coordinator, and the attending physician, if appropriate.

C. "assessment coordinator" means a qualified employee of a central diagnostic and referral agency (CDR) which has been selected and approved to provide assessment services. Assessment coordinators must meet Program standards for selection.

D. "central diagnostic and referral agency" or "CDR" means an approved agency which employs assessment coordinators designated to: make all contractually-mandated face-to-face assessments for the development of substance abuse continuing care treatment plans;

make determinations regarding whether the patient's condition requires mental health and/or substance abuse treatment; make referrals to panel providers; provide short-term counseling (up to two visits per enrollee); and perform aftercare planning and follow-up. The CDR may provide up to three short-term counseling sessions for employees, and may communicate with Employee Assistance Program representatives about assessment and referral activities relating to an employee (when appropriate and when authorized by the employee). The CDR will supply necessary information to the carrier about panel provider performance and selection and other utilization data and statistics as required, including evaluations using designated performance data of panel providers with whom the carrier contracts.

Effective January 1, 2001, CDR's will no longer be utilized under this Appendix B. All the functions and the responsibilities of the CDR will be transferred on January 1, 2001 and performed by the central review organization (CRO) or a qualified designee of the CRO.

E. "central review organization" or "CRO" means a national organization which has been designated to provide the following functions:

1. confirm eligibility of the patient for mental health and/or substance abuse coverage under the Program;

2. authorize and approve inpatient and outpatient mental health treatment, outpatient substance abuse treatment and outpatient psychological testing;

3. re-credential panel providers;

4. monitor CDR performance;

5. exercise managed care protocols, with CDR assistance when appropriate, for those enrollees who require both mental health and substance abuse outpatient visits; and

6. evaluate panel providers and make contracting recommendations to the carrier, using designated performance standards.

F. "clinical nurse specialist" means a person who meets all of the following criteria:

1. possesses a Master of Arts (MA), Master of Science (MS) or Master of Science in Nursing (MSN) degree from an accredited school of nursing. (The master's degree must be in psychiatric nursing or the individual must be eligible for listing in the American Nursing Association Register of Certified Nurses in Advanced Practice as a clinical specialist in Adult Psychiatric Mental Health Nursing, or Child/Adolescent Psychiatric Nursing);

2. has a minimum of five years post-master's degree clinical experience in the field of psychiatric mental health nursing, at least two of which were supervised by a master's level psychiatric nurse (or the equivalent);

3. possesses a license as a Registered Nurse in the jurisdiction in which the practice is to occur;

4. possesses a minimum professional liability coverage of $1 million per occurrence and $1 million aggregate (unless there are state statutes which modify the malpractice requirements in such states); and

5. has signed an agreement with the carrier to participate as a panel provider.

G. "continuing care treatment plan" means a document completed for substance abuse patients by an assessment coordinator at the conclusion of the assessment process. The continuing care treatment plan includes the recommended provider(s), and the type(s) and duration of treatment, and may be modified by the provider and the assessment coordinator in consultation during the course of treatment.

H. "detoxification" means treatment for the physiologic stabilization of an enrollee who is undergoing acute withdrawal from an intoxicating substance. To be covered under this Program, such treatment must be provided by, or under the supervision of, a physician and through a facility approved to provide such care.

I. "detoxification facility" means a hospital or residential treatment facility which is a provider of detoxification services. Such facilities may offer substance abuse rehabilitation treatment subsequent to detoxifying an enrollee.

J. "halfway house treatment" means treatment provided under a semi-residential living arrangement to a substance abuse patient who requires a more structured living environment than outpatient treatment or partial hospitalization treatment would provide, but who does not require full-time residential treatment and care. It provides a controlled environment during the hours of the day the enrollee is not undergoing treatment or is not engaged in specific constructive activity (e.g., working or attending school).

K. "inpatient care" means treatment in:

1. a hospital;

2. a detoxification facility; or

3. a residential care facility.

L. "mental disorder" means any mental, emotional, or personality disorder classified as a mental disorder in categories 290.0 through 319.0 of the most recent edition of the "International Classification of Diseases, 9th Revision, Clinical Modification" excluding alcohol and drug abuse as classified in categories 303.0 through 305.9 (see subsection IV.H., below).

M. "outpatient facility" means an administratively distinct governmental, other public, private, or independent unit or part of such unit that provides outpatient mental health or substance abuse services.

The term includes centers for the care of adults or children such as hospitals, clinics, and partial hospitalization centers. For mental health services, the definition includes Community Mental Health Centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended.

N. "outpatient treatment" or "visit" (including intensive outpatient treatment) means a therapy session provided in an outpatient mental health or substance abuse treatment facility or by an individual mental health or substance abuse provider. All sessions between an individual patient and a provider in a single day, with a total duration of four hours or less, are considered to be a single treatment or visit. If outpatient sessions with all providers in a given day

total more than four hours, such treatment shall be considered partial hospitalization.

O. "panel provider" means a mental health or substance abuse provider who has been selected and has agreed to provide services in accordance with the terms of participation established by the Program and has executed an agreement with the carrier.

P. "partial hospitalization treatment" means a semi-residential level of care for patients with mental health or substance abuse disorders who require coordinated, intensive, comprehensive and multidisciplinary treatment in a structured setting, but less than full-time hospitalization. The patient undergoes therapy for more than four (4) hours a day, and may receive additional services (e.g., meals, bed, recreation);

Q. "psychiatrist" means a physician who is board eligible or board certified in psychiatry and licensed to practice medicine at the time and place services are rendered or performed.

R. "psychologist" means a person who possesses a doctor of philosophy (Ph.D.), doctor of education (Ed.D.), doctor of mental health (DMH), or doctor of psychology (PsyD) degree from a regionally accredited university, has a minimum of five years of post-doctoral clinical experience (at least two of which were supervised by a licensed clinical psychologist or by a board-qualified psychiatrist), possesses a valid license for the independent practice of psychology at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Register of Health Care Providers in Psychology, and participates as a panel provider.

S. "registration" means contact by the provider with the CRO to inform the agency that the enrollee is commencing a course of mental health or substance abuse treatment, to confirm eligibility under the Program, and to obtain any necessary approvals or authorizations.

T. "residential care facility" means an approved inpatient facility which operates 24 hours a day, seven days a week for the provision of residential mental health and/or substance abuse treatment.

U. "social worker" means a person who possesses a master in social work (MSW), master of science in social work (MSSW), or doctor of social work (DSW) degree from a graduate school of social work accredited by the Council on Social Work Education, has a minimum of five years of post-masters or post-doctoral degree clinical social work experience (at least two of which were supervised by a licensed clinical social worker), possesses a valid license or certificate for the independent practice of social work at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Association of Social Work Register of Clinical Social Workers and/or the National Register of Mental Health Care Providers in Social Work, and participates as a panel provider.

V. "substance abuse" means alcohol or drug dependence as classified in categories 303.0 through 305.9 (excluding 305.1 and 305.9) of the most current edition of the "International Classification of Diseases, 9th Revision, Clinical Modification" (see subsection IV.H., below).

II. Terms and Conditions of Coverage

A. Conditions of Benefit Payment

An enrollee is eligible for benefits for covered expenses incurred during an approved course of treatment only if the following conditions or requirements are met:

1. Services must be provided on or after the enrollee's effective date of coverage under the Program and this Appendix.

2. Benefits must be available within the benefit period (see II.B., below).

3. a. In order to be covered up to the benefit maximum under the Program, all covered services rendered in the care and treatment of mental health and substance abuse related disorders must be delivered by panel providers, except in the case of emergency which is subject to the provisions of Section IV.B. of this Appendix. The panel may be comprised of the following types of facilities and providers:

(1) Hospitals

(2) Outpatient facilities

(3) Detoxification facilities

(4) Residential care facilities

(5) Partial hospitalization facilities

(6) Halfway houses

(7) Skilled nursing facilities

(8) Psychiatrists

(9) Psychologists

(10) Social workers

(11) Clinical nurse specialists

(12) Outpatient clinics

b. In addition, if due to the unavailability of specialized services, the enrollee must be referred to a non-panel provider, then, in such cases only, non-panel providers will be covered up to the benefit maximum subject to App. B, II.B.4.a. and b., provided the enrollee is referred by the CRO or a panel provider and the services are authorized, in advance, by the CRO.

c. Services provided in accordance with App. B, IV.B.3. are covered up to the benefit maximum.

4. Outpatient treatment by clinical nurse specialists, social workers or psychologists as independent practitioners must be rendered by participating panel providers.

5. In order to be eligible for benefits for residential and/or halfway house substance abuse treatment, the enrollee must be assessed by an assessment coordinator from a designated CDR. Expenses for days of treatment during an admission to a residential treatment facility or halfway house program will not be covered prior

to the time assessment and a treatment plan are obtained from a substance abuse assessment coordinator. If such coordinator makes a determination of substance abuse and the assessment specifies a level of care which includes residential or halfway house treatment, such treatment will be covered subject to other Program provisions.

6. Detoxification admissions must be reported to the CRO within 24 hours of admission. In such cases, the CRO will notify the CDR assigned to that location. The CDR's assessment coordinator will contact the enrollee during or after the detoxification and develop a plan for treatment subsequent to detoxification (continuing care treatment plan). Detoxification confinements longer than three days must be approved by the CDR or CRO.

7. Mental health inpatient services and admissions must be authorized by the CRO within 24 hours of admission.

8. Partial hospitalization treatment and outpatient mental health and substance abuse treatment must be registered with the CRO. This procedure does not apply to day, night or outpatient treatment services rendered as part of an authorized substance abuse continuing care treatment plan.

9. Admission to a skilled nursing facility must be for the treatment of a mental health condition, must be authorized by the CRO and must immediately follow a confinement for the same condition.

10. Benefits are payable subject to the provisions and limitations of the Program, regardless of the treatment plan developed through assessment.

11. Benefits payable under this Appendix for an enrollee eligible for Medicare shall be paid in accordance with the terms and conditions pertaining to Medicare as specified in App. A, II.E.

B. Benefit Period

1. a. An enrollee is eligible for a maximum of 45 days of covered inpatient mental health care

within the benefit period set forth in App. A, II.B.1.

b. An enrollee is eligible for a maximum of 45 days of covered inpatient substance abuse care including detoxification within the benefit period set forth in App. A, II.B.1.

c. Each day of care utilized for inpatient substance abuse treatment is charged against the unused portion of the 45-day inpatient mental health benefit period. Likewise, each day of inpatient mental health care is charged against the unused portion of the 45-day inpatient substance abuse treatment period.

2. a. An enrollee is eligible for a maximum of 90 days of care in a partial hospitalization treatment facility within the benefit period set forth in App. A, II.B.1.

b. Each day of inpatient care for mental health or substance abuse treatment reduces by two the number of days of care available for mental health or substance abuse partial hospitalization treatment. Each two days of partial hospitalization treatment reduces by one the number of days of care available for inpatient care.

3. a. An enrollee is eligible for a maximum of 90 days of mental health care in an approved skilled nursing facility within the benefit period set forth in App. A, II.B.1.

b. Each day of inpatient care for mental health treatment within the benefit period reduces by two the number of available days for skilled nursing facility care. Each two days of medical care for the treatment of mental disorders in a skilled nursing facility reduces by one the number of days of inpatient medical care available for the treatment of mental health related disorders in a hospital.

4. a. An enrollee is eligible for 20 outpatient mental health visits at 100% coverage and an additional 15 visits at 75% coverage for outpatient mental health treatment for both

facility and professional services per calendar year.

b. An enrollee is eligible for 35 outpatient substance abuse visits at 100% coverage for both facility and professional services per calendar year.

c. When an enrollee requires mental health and/or substance abuse outpatient treatment, the CRO and/or CDR (where appropriate) shall exercise managed care protocols after a total of six outpatient visits and shall monitor the treatment plan(s) to assure appropriate coordinated care.

(1) Inpatient substance abuse care assessments, referrals and continuing care treatment follow-up by CDRs are mandatory and do not reduce the enrollee's outpatient visit entitlement.

(2) Voluntary utilization of the CDR for outpatient mental health or substance abuse assessment and referral does not count as an outpatient visit.

d. Anorexia nervosa, bulimia and other conditions covered by Appendix B which are appropriate for case management, may be case managed by the CRO utilizing the case management procedures described in App. A, III.K. with any alternative benefit plan being limited to the dollar pool created using the 45-day inpatient benefit described in this section.

e. Outpatient psychological testing is not considered "treatment" and is not charged against the outpatient visit maximum.

f. Each visit by one or more members of an enrollee's family for family counseling counts as one visit applicable to the enrollee's annual outpatient treatment maximum.

5. An enrollee shall be eligible for a lifetime maximum of 90 days of substance abuse treatment in a panel halfway house.

6. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of 60 days. Accordingly, there must be a lapse of at least 60 consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential care facility or any other facility to which the 60-day benefit renewal period of this Appendix and Appendix A apply (see App. A, II.B.3. for example), and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits are paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse partial hospitalization care program, a substance abuse halfway house, a hospice program or is receiving home health care visits, the 60-day renewal period is broken, whether or not benefits are paid as a result of receipt of such services.

C. Non-Completion of the Substance Abuse Treatment Plan by an Employee

Employees entering detoxification, residential or halfway house treatment facilities are required to receive a continuing care treatment plan from the assessment coordinator as part of the assessment process. Non-completion of the portions of such treatment plan which are covered services (including outpatient and partial hospitalization programs) will result in the following actions being taken:

1. The carrier will send a letter to the employee and to the Corporation’s Medical Director notifying them of the failure to complete the treatment plan.

2. The letter will notify the employee that if a second continuing care treatment plan is established and not completed, a maximum of up to a $500 overpayment will have occurred as a result of medical expenses incurred on the employee's behalf.

3. If the employee fails to complete a second continuing care treatment plan, the carrier will notify the employee and the Corporation's Medical Director of such failure and of any overpayment. The provisions of Article I, Section 9, of the Program will apply.

   However, if the employee establishes to the satisfaction of the Corporation's Medical Director that such employee is motivated towards recovery and that the treatment plan was discontinued for a satisfactory reason, then such overpayment will not have occurred.

4. For each subsequent non-completion of a treatment plan, the maximum overpayment amount will increase in increments of $250, up to a maximum overpayment amount of $1,000 for each occurrence.

III. Coverages

A. Inpatient Care (Mental Health and Substance Abuse)

1. Inpatient mental health and substance abuse care is subject to the benefit period set forth in App. B, II.B.1.

2. Inpatient services by non-panel providers are subject to the provisions of Sections IV.B.2. (for mental health treatment) and IV.B.4. (for substance abuse treatment) of this Appendix.

3. Coverage includes the following inpatient services when provided and billed by the facility:

   a. semiprivate room, including general nursing services, meals and special diets;

   b. laboratory and pathology examinations related to the treatment received in the facility;

   c. drugs, biologicals, solutions and supplies related to the treatment received and used while the enrollee is in the facility;

   d. supplies and use of equipment required in the care and treatment of the enrollee's condition;

e. professional and ancillary services, including those of other trained staff, necessary for patient care and treatment, including diagnostic examinations;

f. individual and group therapy;

g. counseling for family members;

h. electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy; and

i. supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients.

4. Psychological testing is covered when administered by a panel psychologist, medically indicated, approved by the CRO and directly related to the organic medical or functional condition or when it has an integral role in rehabilitative or psychiatric treatment programs.

5. Coverage for medical care for the treatment of mental disorders is limited to (i) individual psychotherapeutic treatment, (ii) family counseling for the enrollee's family, (iii) group psychotherapeutic treatment, (iv) psychological testing when prescribed or performed by a physician, and (v) electroshock therapy and anesthesia for electroshock therapy.

B. Skilled Nursing Facility Care (Mental Health Only)

1. Mental health care in a skilled nursing facility is subject to the benefit period set forth in App. B, II.B.3.

2. Coverage includes services as described in A.3., above, and medical care. Medical care in a skilled nursing facility is limited to a maximum of two physician visits per week.

C. Halfway House Care (Substance Abuse Only)

1. Substance abuse care in a halfway house is subject to the benefit maximum set forth in App. B, II.B.5.

2. Coverage includes the following halfway house services when provided and billed by the facility:

   a. bed and board;

   b. intake evaluation;

   c. up to one routine drug screen per week;

   d. individual and group therapy or counseling; and

   e. counseling for family members.

D. Partial Hospitalization Care (Mental Health and Substance Abuse)

1. Mental health and substance abuse care in partial hospitalization care treatment facilities is subject to the benefit period set forth in App. B, II.B.2.

2. Inpatient services by non-panel providers are subject to the provisions of Sections IV.B.2. (for mental health treatment) and IV.B.4. (for substance abuse treatment) of this Appendix.

3. Coverage for treatment in a partial hospitalization care treatment facility includes the following services when provided and billed by the facility:

   a. laboratory examinations related to the treatment received in the facility;

   b. prescribed drugs, biologicals, solutions and supplies related to the treatment received, including, for substance abuse, drugs to be taken home;

   c. supplies and use of equipment required in the care of the enrollee's condition;

   d. professional and ancillary services including those of other trained staff, necessary for the treatment of ambulatory

enrollees, including diagnostic examinations;

e. individual and group therapy;

f. psychological testing;

g. counseling for family members;

h. electroshock therapy for a mental health patient when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy; and

i. an enrollee admitted to partial hospitalization treatment also is entitled to a semiprivate room, general nursing services, meals and special diets.

E. Outpatient Care (Mental Health and Substance Abuse)

1. Outpatient mental health and substance abuse treatment is subject to the benefit maximums set forth in App. B, II.B.4.a. and b.

2. Covered outpatient mental health and substance abuse treatment includes the following:

a. Services provided and billed by facilities

(1) professional and other staff and ancillary services made available by facilities to ambulatory patients;

(2) prescribed drugs and medications dispensed by a facility in connection with treatment received at the facility; and

(3) electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy.

b. Services provided and billed by facilities or professional providers

(1) Individual psychotherapeutic treatments of a duration of 20 minutes or more (all sessions with a given provider on a single day, with a total duration of four hours or less, shall constitute a single "visit" and be reimbursed as a single unit of service).

(a) Benefits will be paid as set forth in App. B, II.B.4.a. for outpatient mental health services at 100% of the panel reimbursement amount for the first 20 outpatient mental health treatments and 75% for the next 15 treatments per calendar year when provided by panel providers. Services rendered by non-panel providers as provided in App. B, II.A.3.b. and in App. B, IV.B.3. shall be covered up to the benefit maximums. Otherwise, when outpatient mental health services are received from a non-panel provider, without referral by the CRO, such services must be rendered by qualified physicians or qualified facilities, and will be reimbursed at 50% of the amount payable to panel providers for comparable services. Such reimbursement will be made only to the primary enrollee.

(b) Benefits will be paid as set forth in App. B, II.B.4.b. for individual outpatient substance abuse treatment at 100% of the panel reimbursement amount for 35 visits per calendar year when provided by panel providers. No benefits are payable for treatment by non-panel providers, except when services

are rendered by non-panel providers as provided in App. B, II.A.3.b. in which case such treatment shall be covered up to the benefit maximum.

(2) Group mental health and substance abuse treatment is covered subject to the payment provisions in subsections (a) or (b) above.

(3) Family counseling to members of the patient's family is covered subject to the payment provisions in subsections (a) or (b) above.

3. Outpatient psychological testing is covered only when preauthorized by the CRO and performed by a panel provider. Such testing is not considered treatment and therefore is not subject to the benefit period maximum.

IV. Limitations and Exclusions

A. Panel providers are required to contact the CRO to verify eligibility and receive prior authorization of all non-emergency inpatient and outpatient mental health and substance abuse services.

B. Coverage will be limited to the following when rendered by or through non-panel providers:

1. Emergency services. Providers must contact the CRO within 24 hours of the inpatient admission or outpatient treatment for authorization of such services.

2. Non-emergency services. Benefits for mental health services provided by qualified physicians or facilities who/which are non-panel providers are limited to 50% of the panel reimbursement amount unless the enrollee is referred to the non-panel physician or facility by a panel provider. The carrier will make payment to the primary enrollee. Payment to the provider, including any balance, is the responsibility of the enrollee.

3. Outpatient services. Services provided by non-panel physicians (e.g., internists or general practitioners) must be registered with the CRO

after the first visit and are limited to a maximum of one visit.

4. Substance abuse treatment. Coverage for substance abuse treatment does not include services provided by non-panel providers except for emergency detoxification.

C. Coverage is not available for services for treatment of mental disorders which, according to generally accepted medical standards (as determined by the carrier), are not amenable to favorable modification, except that coverage is available for the period necessary to determine that the disorder is not amenable to favorable modification, or for the period necessary for the evaluation and diagnosis of mental deficiency or retardation.

D. Coverage for substance abuse treatment does not include professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations or other diagnostic procedures unless therapy, counseling or psychological testing are provided on the same day.

E. Coverage does not include family counseling which is rendered by a provider other than the provider for the family member in the course of treatment. Furthermore, reimbursement will be provided only in conjunction with services rendered on behalf of enrollees covered under the General Motors Health Care Program.

F. Coverage does not include diversional therapy.

G. Coverage does not include psychological testing if used as part of, or in connection with, vocational guidance, training or counseling.

H. Coverage under this Appendix does not include treatment of tobacco use disorder (ICD-9 Code 305.1) or treatment of non-dependent abuse of substances such as laxatives, patent medicinals, etc. (ICD-9 Code 305.9).

I. General Limitations and Exclusions under Section IV. and subsections II.C., E., G., and H. of the Terms and Conditions of Appendix A are equally applicable under this Appendix.

APPENDIX C

DENTAL COVERAGE

I. Enrollment Classifications

Dental coverage for a primary enrollee may include coverage for eligible secondary enrollees as defined in the Program.

II. Description of Benefits

Dental benefits will be payable, subject to the conditions herein, if an enrollee incurs a covered dental expense.

III Covered Dental Expenses

Covered dental expenses are the usual charges of a dentist which an enrollee is required to pay for services and supplies which are necessary for treatment of a dental condition, but only to the extent that such charges are reasonable and customary charges, as herein defined, for services and supplies customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of dental practice. Such expenses shall be only those incurred in connection with the following dental services which are performed, except as otherwise provided in Section VII.B., by a licensed dentist and which are received while coverage is in force.

A. The following covered dental expenses shall be paid at 100% of the reasonable and customary charge:

1. Routine oral examinations and prophylaxes (scaling and cleaning of teeth), but not more than twice each in any calendar year. Up to three cleanings per calendar year will be allowed if there is a documented history of periodontal disease. Up to four cleanings per calendar year will be covered for two full calendar years following periodontal surgery.

2. Topical application of fluoride provided that such treatment shall be a covered dental expense only for enrollees under 20 years of age, unless a specific dental condition makes such treatment necessary.

3. Space maintainers that replace prematurely lost teeth for children under 19 years of age.

4. Emergency palliative treatment.

B. The following covered dental expenses shall be paid at 80% of the reasonable and customary charge:

l. Dental x-rays, including full mouth x-rays once in any period of five consecutive calendar years, supplementary bitewing x-rays once in any calendar year and such other dental x-rays including, but not limited to, those specified in this paragraph, as are required in connection with the diagnosis of a specific condition requiring treatment.

2. Extractions.

3. Oral surgery.

4. Amalgam, silicate, acrylic, synthetic porcelain, and composite, or other American Dental Association (ADA)-approved direct restorative materials that meet Program standards and are deemed appropriate by the carrier, to restore diseased or accidentally injured teeth.

5. General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery.

6. Treatment of periodontal and other diseases of the gums and tissues of the mouth.

7. Endodontic treatment, including root canal therapy.

8. Injection of antibiotic drugs by the attending dentist.

9. Cosmetic bonding of eight front teeth for children 8 through 19 years of age if required because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of three consecutive calendar years.

C. The following covered dental expenses shall be paid at 50% of the reasonable and customary charge:

1. Initial installation of fixed bridgework (including inlays and crowns as abutments).

2. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation).

3. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

   a. the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;

   b. the existing denture or bridgework cannot be made serviceable and, if it was installed under this dental coverage, at least five years have elapsed prior to its replacement; or

   c. the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

   Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a covered dental expense.

4. Orthodontic procedures and treatment (including related oral examinations) consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy) for enrollees under 19 years of age, provided, however, that benefits will be paid after attainment of age 19 for continuous treatment which began prior to such age.

5. Services and procedures for the conservative diagnosis and treatment of temporomandibular joint (TMJ) dysfunction including, but not limited to, related oral examinations, consultations, x-rays, occlusal equilibration, diagnostic models and casts, temporary splints and orthotic appliances. Coverage does not include orthodontic treatment except as provided in App. C, III.C.4. above.

6. Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of three consecutive calendar years.

7. Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally injured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, composite, or other American Dental Association (ADA)-approved materials that meet Program standards and are used for direct filling restoration.

8. Implantology

IV. Maximum Benefits For Other Than Accidental Dental Injury

The maximum benefit payable for all covered dental expenses incurred during a calendar year commencing January 1 and ending the following December 31 (except for services described in Section III.C.4. and 5. above, and in Section XI below) shall be $1,700 for each enrollee, with a maximum of $1,600 applicable to covered dental expenses provided prior to January 1, 2005.

For covered dental expenses in connection with orthodontics (including related oral examinations), described in Section III.C.4. above, the maximum benefit payable shall be $2,000 during the lifetime of each enrollee, with a maximum of $1,800 applicable to covered expenses for services provided prior to January 1, 2005.

For covered dental expenses in connection with TMJ treatment described in Section III.C.5. above, the maximum benefit payable shall be $2,000 during the lifetime of each enrollee.

V. Pre-Determination of Benefits

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the carrier prior to the commencement of the course of treatment.

The carrier will notify the enrollee and the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount as provided in Sections III. and IV., determined in accordance with the limitations set forth in Section VI.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the carrier reserves the right to make a determination of benefits payable taking into account alternate procedures, services, or courses of treatment, based on accepted standards of dental practice. To the extent verification of covered dental expenses cannot reasonably be made by the carrier, the benefits for the course of treatment may be for a lesser amount than would otherwise have been payable.

This pre-determination requirement will not apply to courses of treatment under $200 or to emergency treatment, routine oral examinations, x-rays, prophylaxes, and fluoride treatments.

VI. Limitations

A. Restorative

l. Gold, Baked Porcelain Restorations, Crowns and Jackets

If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration selected by the enrollee and the dentist. The balance of the treatment charge remains the responsibility of the enrollee.

2. Reconstruction

Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and their cost remains the responsibility of the enrollee.

B. Prosthodontics

l. Partial Dentures

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that the enrollee and dentist may choose to use, and the balance of the cost remains the responsibility of the enrollee.

2. Complete Dentures

If, in the provision of complete denture services, the enrollee and dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and the balance of the cost remains the responsibility of the enrollee.

3. Replacement of Existing Dentures

Replacement of an existing denture will be a covered dental expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a covered dental expense only if at least five years have elapsed since the date of the initial installation of that appliance under this dental coverage, except as provided in Section III.C.3. above.

C. Orthodontics

l. If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed.

2. The benefit payment for orthodontic services shall be only for months that coverage is in force.

VII. Exclusions

Covered dental expenses do not include and no benefits are payable for:

A. charges for services for which benefits are provided under other health care coverages;

B. charges for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist;

C. charges for veneers or similar properties of crowns and pontics placed on, or replacing teeth, other than the ten upper and lower anterior teeth;

D. charges for services or supplies that are cosmetic in nature (except as provided in Section III.B.11.), including charges for personalization or characterization dentures;

E. charges for prosthetic devices (including bridges), crowns, inlays, and onlays, and the fitting thereof which were ordered while the enrollee was not covered for dental coverage or which were ordered while the enrollee was covered for dental coverage but are finally installed or delivered to such enrollee more than 60 days after termination of coverage;

F. charges for the replacement of a lost, missing, or stolen prosthetic device;

G. charges for failure to keep a scheduled visit with the dentist;

H. charges for replacement or repair of an orthodontic appliance;

I. charges for services or supplies which are compensable under a Worker's Compensation or Employer's Liability Law;

J. charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the enrollee's employer;

K. charges for services or supplies for which no charge is made that the enrollee is legally obligated to pay or for which no charge would be made in the absence of dental coverage;

L. charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;

M. charges for services or supplies which do not meet accepted standards of dental practice, including, but not limited to, charges for services or supplies which are experimental in nature;

N. charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;

O. charges for services or supplies from any governmental agency which are obtained by the enrollee without cost by compliance with laws or regulations enacted by any Federal, state, municipal, or other governmental body;

P. charges for any duplicate prosthetic device or any other duplicate appliance;

Q. charges for any services to the extent benefits are payable under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision thereof;

R. charges for the completion of any insurance forms;

S. charges for sealants and for oral hygiene and dietary instruction;

T. charges for a plaque control program;
or

U. charges for services or supplies related to periodontal splinting.

VIII. Proof of Claim

The carrier reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for dental benefits. As part of the basis for determining benefits payable, the carrier may require x-rays and other appropriate diagnostic and evaluative materials.

IX. Alternative Dental Coverage

A. The Corporation may make arrangements for eligible enrollees to enroll for approved and qualified alternative dental coverages which may provide for benefits and/or copayments which are different from those specified in this Appendix. The Corporation's contributions toward coverage under such alternative dental coverage shall not be greater than the amount the Corporation would have contributed for dental coverage herein.

B. At its option, the Corporation may implement a dental network under which coverage may be limited to covered services obtained from network providers and/or benefits may be reduced or eliminated for covered services obtained from non-network providers. At the Corporation's option, such a network may be substituted for the standard dental coverage under this Appendix, for alternative dental coverage, or both.

X. Definitions

As used in this Appendix, the terms identified below have the meanings stated.

A. "dentist" means a legally licensed dentist practicing within the scope of such dentist's license. As used herein, the term "dentist" also includes a legally licensed physician authorized by license to perform the particular dental services such physician has rendered.

B. "reasonable and customary charge" is defined in Article IV, Section 15 of the Program. However, for purposes of this Appendix "area" means a metropolitan area, a county or such greater area as is necessary to obtain a representative cross-section of dentists rendering such services or furnishing such supplies.

C. "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists, for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

D. "orthodontic treatment" means preventive and corrective treatment of those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning (except for preventive treatment) of teeth to establish normal occlusion.

E. "ordered" means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays, or onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

F. "temporomandibular joint (TMJ) dysfunction/disorder" refers to a disorder of the supporting and regulating structures of the jaws including changes in muscles, ligaments and nerves; these changes are generally reversible by time and/or treatment.

G. "accidental dental injury" means an injury to sound natural teeth caused by external forces which occur as the result of a traumatic incident which is sudden and unforeseen and which are not ordinarily associated with chewing or the reasonable use of teeth in normal activity which results in the need for repair and/or replacement of dental structures.

XI. Accidental Dental Injury

For services obtained as the result of an accidental dental injury which occurs while the enrollee is eligible for coverage and enrolled, benefits in excess of the maximums as described in Section IV. are available for repair and/or care of sound natural teeth subject to the following conditions.

A. Benefits are available when:

1. services are covered under this Appendix (except for orthodontic treatment or treatment of

temporomandibular joint dysfunction) or would have been covered under this Appendix in the absence of the frequency limitations provided in Sections III. and VI.;

2. the maximum benefits described in Section IV. have been exceeded;

3. the enrollee has sustained a covered accidental dental injury, which is verifiable and documented in the record;

4. services are the direct result of the accidental dental injury; and

5. services are provided within one year subsequent to the date of the accident except:

   a. when acceptable evidence is presented to the carrier that unusual or special dental and/or medical needs prevented the provision of services within that time period; or

   b. when the dental development of the injured enrollee is incomplete at the time of injury, in which event services must be provided no later than two years after full development is reached.

B. Benefits for covered services are subject to:

1. the reasonable and customary charges for repair and/or care of sound natural teeth;

2. a 20% copayment; and

3. a maximum benefit payment per enrollee of $12,000 per qualified occurrence and per lifetime.

C. Coverage under this Section is not available for services for injury caused by normal wear and tear on the teeth or on a prosthetic dental appliance.

APPENDIX D

VISION COVERAGE

I. Enrollment Classifications

Vision coverage for a primary enrollee may include coverage for eligible secondary enrollees as defined in the Program.

II. Description of Benefits

Vision benefits will be payable, subject to the conditions herein, if an enrollee incurs a covered vision expense.

III. Definitions

As used herein:

A. "ophthalmologist" means any licensed doctor of medicine or osteopathy legally qualified to practice medicine, including the diagnosis, treatment, and prescribing of lenses related to conditions of the eye.

B. "optometrist" means any person legally licensed to practice optometry as defined by the laws of the state in which the service is rendered.

C. "optician" means one who makes or sells eyeglasses prescribed by an ophthalmologist or optometrist to cure or correct defects in the eyes, and grinds the lenses or has them ground according to prescription, fits them into a frame, and adjusts the frame to fit the face.

D. "participating provider" means an ophthalmologist, optometrist, or optician who has signed an agreement with the carrier covering reimbursement, quality, service standards and other terms and conditions connected with providing covered vision services to enrollees.

E. "nonparticipating provider" means an ophthalmologist, optometrist, or optician who has not signed an agreement with the carrier covering reimbursement, quality, service standards and other terms and conditions connected with providing covered vision services to enrollees.

F. "contact lenses" means ophthalmic corrective lenses, as prescribed by an ophthalmologist or optometrist, to be fitted directly to the enrollee's eyes.

G. "lenses" means ophthalmic corrective lenses, as prescribed by an ophthalmologist or optometrist, to be fitted into a frame.

H. "frame" means a standard eyeglass frame into which two lenses are fitted.

I. "covered vision expense" means the reasonable and customary charges for vision care services and materials, as described in Section IV., when provided by ophthalmologists, optometrists, and opticians for each enrollee.

J. "corrective eye surgery" means a surgical procedure used to alter the cornea or shape/surface of the eye in order to improve visual acuity, correct vision conditions such as myopia, hyperopia, or astigmatism and reduce or eliminate the reliance on eyewear. Such surgeries can include, but are not necessarily limited to, Laser- assisted In-Situ Keratomileusis (LASIK), PhotoRefractive Keratectomy (PRK) and Radial Keratotomy (RK).

K. "reasonable and customary charge" as used in this Appendix also refers to scheduled or other contracted amounts of payment used by carriers with participating provider arrangements. The carrier is responsible for determining the appropriate reasonable and customary charge for a given provider and service or material, and such determination shall be conclusive.

IV. Benefits

Benefits will be paid for the covered vision expenses described in A., B., and C. below, less any copayment as described in D. below.

A. Vision Examinations:

1. Refraction, including case history, coordinating measurements, and tests;

2. The prescription of glasses where indicated; and

3. Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist.

B. Lenses and Frames:

When lenses are prescribed by an ophthalmologist or optometrist, the necessary materials and professional services connected with the ordering, preparation, fitting, and adjusting of:

1. Lenses (single vision, bifocals, trifocals, lenticular). If the enrollee selects lenses, the size of which results in an additional charge, only the reasonable and customary charge for normal size lenses of the same material and prescription will be considered a covered vision expense. If the enrollee selects photochromic lenses or lenses with a tint other than Number 1 or Number 2, only the reasonable and customary charge for clear lenses of the same material and prescription will be considered a covered vision expense.

2. Contact lenses following cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye except by their use, or when medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature. If contact lenses are prescribed for any other reason, $80 is the maximum amount that will be considered a covered vision expense

3. Frames. If frames are obtained from a participating provider, the enrollee may make a selection from the display shown by the participating provider and there will be no out-of-pocket expense to the enrollee other than as described under "copayments". However, if the selection at the participating provider is not from the display shown, or if the enrollee obtains frames from a nonparticipating provider, $16 is the maximum amount that will be considered a covered vision expense until January 1, 2004 and $24 thereafter.

C. Corrective Eye Surgery: Effective January 1, 2004, corrective eye surgery performed by an ophthalmologist will become a covered service. Coverage includes any related pre and post-surgical professional services, facility expense and medically necessary supplies. Coverage is subject to the following provisions:

1. An enrollee may not receive benefits for both corrective eye surgery and for frames and/or lenses (including contact lenses) in the same calendar year;

2. Upon proof of payment to the corrective eye surgery provider, the carrier will reimburse the primary enrollee for covered expense, up to the lesser of the charges or the maximum benefit of $295.00 in any four (4) year period; and

3. An enrollee receiving benefits for corrective eye surgery in any one calendar year will be ineligible for lens (including contact lens) and/or frame benefits for that year and three (3) subsequent years. For example, an enrollee undergoing corrective eye surgery in 2004 would be eligible for lens and/or frame benefits in 2008. Such enrollees will be eligible for benefits for an annual exam, and will have access to the participating provider fee schedule for non-covered services and for lenses and/or frames for which no benefits are payable.

D. Copayments:

For each enrollee, there is a $7 copayment applicable to the covered vision expense for each vision examination and a $10 copayment for the combined covered vision expenses for lenses, contact lenses, and frames. The total copayment for each enrollee, during a calendar year, will not exceed $17.

V. Frequency Limitations

For each enrollee, there are the following limitations on the frequency with which charges for certain services and materials will be considered covered vision expenses:

Vision Examination	-	Once during a calendar year, except as provided in Section IV.A.3.
Lenses	-	Once during a calendar year, except as provided in Section IV.C.
Frames	-	Once during two consecutive calendar years, except as provided in Section IV.C.

The limitations on lenses, contact lenses, and frames apply whether or not they are a replacement of lost, stolen, or broken lenses, contact lenses, or frames.

VI. Exclusions

A. Any lenses which do not require a prescription;

B. Medical or surgical treatment of the eye, except as provided in Section IV.C.;

C. Drugs or any other medication;

D. Procedures determined by the carrier to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography;

E. Vision examinations or materials furnished for any condition, disease, ailment, or injury arising out of or in the course of employment; and

F. Vision examinations performed and lenses and frames ordered:

1. before the enrollee became covered for this coverage;

2. after the termination of the enrollee's coverage; or

3. to the extent that they are obtained without cost to the enrollee.

VII. Vision Network

A. The carrier has implemented a network of participating providers who agree to accept reimbursement according to a schedule for the covered vision services and materials described in Section IV.A. and B. without enrollee copayments.

B. If an enrollee uses a participating provider to obtain covered services, the carrier will reimburse the provider without enrollee copayment as specified below:

1. the scheduled amount (which shall be payment in full) for eye examinations, normal-size clear, Number 1 or Number 2 tinted lenses; and medically necessary contact lenses (see Section IV.B.1. and 2.);

2. the scheduled amount (which is payment in full) of $24 for eyeglass frames with a retail value of $80 or less. If an eyeglass frame with a retail value greater than $80 is selected, the enrollee will be responsible for the discounted price

(participating providers discount frames with the retail cost in excess of $80), less $24; and

3. the scheduled amount of $65 for contact lenses, which do not meet the criteria in Section IV.B.2. The enrollee will be responsible for any amount greater than $80.

C. If an enrollee resides 25 miles or less from a participating provider but obtains covered services from a non-participating provider (other than an ophthalmologist), the carrier will reimburse the enrollee the scheduled amounts. The enrollee will be responsible for paying the provider, including any remaining balance. Reimbursement to the enrollee for covered services received from non-participating ophthalmologists will be made at the reasonable and customary amount, less the enrollee copayment (see Section IV.D.).

D. If an enrollee resides more than 25 miles from a participating provider and obtains covered services from a non-participating provider (including an ophthalmologist), the carrier will reimburse the enrollee in accordance with Section IV. above.

APPENDIX E

EXTENDED CARE COVERAGE

I. Definitions

To the extent they are not in conflict with the following, the definitions contained in Article IV and in Appendix A of the Program are incorporated herein by reference. For the purposes of this Appendix:

A. "nurse professional" means a registered nurse (RN), a licensed practical nurse (LPN), nurse practitioner, or nurse clinician, who is legally qualified and licensed to perform nursing services at the time and place services are rendered; or other individual who meets Program standards, and who is appropriately licensed where required;

B. "nursing home" means a basic or intermediate care facility licensed and operated in accordance with the laws or other regulations pertaining to nursing homes, which provides 24-hour nursing care under medical supervision to ill or disabled enrollees who are unable to care for themselves, and which meets Program standards and is approved by the carrier; and

C. "Program standards" means for purposes of this Appendix E, standards established by the Appendix E carrier; and

D. "unskilled care" means care which, although prescribed by a physician, is typically provided to assist the patient with the activities of daily living including, but not limited to, bathing, dressing, incontinent care, skin care, and meal preparation. Although such care requires only basic skills and training, it may be provided in a licensed nursing home, by a home health care agency, or by a privately contracted, qualified nurse professional.

The Extended Care Coverage (ECC) carrier shall have discretionary authority to interpret, construe and apply the above provisions of the Program. The carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

II. Eligibility, Enrollment and Contributions

A. Extended Care Coverage (ECC) is available to primary enrollees eligible for and enrolled in coverage under Appendix A of the Program, with the exception of:

1. Employees in Hawaii;

2. Employees classified as Flexible Service Employees, Expatriates or Cooperative Students;

3. Primary enrollees who reside in Canada and elect the Optional Canadian Health Care Coverage (OCHCC); and

4. Employees whose service date is on or after January 1, 2001.

5. Retirees and surviving spouses who have waived, discontinued or otherwise terminated ECC in their own right and who have not been (a) continuously enrolled either in ECC under another primary enrollee or in the Comprehensive Medical Expense Insurance Program coverage applicable to OCHCC enrollees, or (b) included in the coverage elections of an employee eligible for coverage under this Program.

B. With the exception of sponsored dependents, secondary enrollees are eligible for ECC if they are eligible and enrolled for Appendix A coverage under a primary enrollee enrolled in ECC.

C. An ECC-eligible employee who elects and is enrolled for coverage under Appendix A of the program will be enrolled automatically in ECC, regardless of the enrollment option elected (BMP, EMP, or HMO). If the employee's coverage under Appendix A is terminated, or if the employee's status changes to one which would not entitle the employee to ECC, the ECC is terminated; if the employee's coverage under Appendix A is reinstated, or if the employee returns to a status which entitles the employee to ECC, it will be reinstated. Employee contributions for ECC will be included in the calculation of contributions for the Medical Plan options.

D. Retirees and surviving spouses eligible for Medical Plan coverage under the Program will make a separate contribution for ECC, if it is elected. The

contribution schedule is subject to periodic adjustment, at the discretion of the Corporation.

1. The enrollment status [self-only, self and spouse, self and child(ren) or self and family] for ECC will be the same as that for the Medical Plan enrollment status chosen by the retiree/surviving spouse.

2. A retiree or surviving spouse who does not elect to enroll in, or to maintain enrollment in ECC will not be permitted to reenroll in ECC at a later date unless, during the intervening period, the retiree or surviving spouse has been enrolled in ECC under another primary enrollee, included as a secondary enrollee in the Medical Plan elections of a salaried employee or enrolled under the OCHCC. The same prohibition will apply to an individual who becomes a salaried retiree or a surviving spouse of a salaried employee or retiree and elects not to enroll in ECC at the time of retirement or enrollment as a surviving spouse, or who initially elects but then discontinues ECC.

III. Covered Expenses and Benefits

A. ECC coverage applies only to long term and/or custodial nursing care needs. Accordingly, the situations in which ECC benefits may be payable, subject to the specified maximums, are if:

(1) an enrollee exhausts hospital or skilled nursing facility or home health care coverage under Appendix A of the Program;

(2) home health care services for an enrollee exceed the requirements for coverage under Appendix A;

(3) an enrollee incurs expenses for private duty nursing services (except while a patient in a hospital, skilled nursing facility or nursing home); or

(4) an enrollee incurs expenses for custodial care which is not covered under Appendix A.

B. There are no deductibles and copayments applicable to services covered under this Appendix.

C. Determinations made by carriers administering Appendix A coverages, with regard to the nature of care being

provided to an enrollee will not control benefit determinations for ECC, nor will determinations of the ECC carrier control benefit determinations under other appendices of the Program. To the extent that the ECC benefits payable are a function of the nature of the service being performed (i.e., skilled, unskilled or a combination of the two), the medical necessity of the services, the reasonable and customary charge for such services or the approved status of the provider for ECC purposes, the ECC carrier shall have discretionary authority to interpret, apply and construe the provisions of the Program. The ECC carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

D. The maximum benefit payable under this Appendix for services incurred during any one calendar year (January 1 through December 31) is $50,000 for each enrollee, subject to the provisions below. Claims must be received by the carrier no later than the last day of the calendar year following the calendar year in which the expenses are incurred.

1. Coverage will be provided at the reasonable and customary daily rate for skilled or mixed skilled and unskilled care for:

a. Medically necessary non-custodial hospital or skilled nursing facility admissions which exhaust Appendix A limits;

b. Skilled hospital or skilled nursing facility admissions which are not covered under Appendix A due to the Appendix A carrier's determinations that the admissions are custodial in nature;

c. Admissions to nursing homes approved by the ECC carrier, for services considered by the ECC carrier to be skilled in nature; and

d. Skilled care being provided in the home by a qualified home health care agency or by a qualified nurse professional but which does not meet the criteria for coverage under the Appendix A provisions, exceeds the intermittent or part-time criteria or exhausts limits of the option elected.

However, if benefits are denied or reduced, under Appendix A, solely due to failure to use providers approved by the Appendix A carrier, no benefits are payable.

2. Coverage will be provided at a maximum of $35 per day for unskilled care delivered in a hospital, skilled nursing facility, nursing home or in the patient's home by nurse professionals.

3. Coverage will be provided for medical supplies not covered under another provision of the Program (e.g., prescription drugs, durable medical equipment) for an enrollee admitted to a hospital or skilled nursing facility for unskilled custodial care, or for an enrollee confined to the home who is receiving benefits under this Appendix but not receiving home health care services under Appendix A. For enrollees receiving benefits for home health care services under Appendix A, medical supplies are covered (see Section III.D.2.c.(3)). Supplies covered under this Appendix are in addition to the $35 daily allowance for actual care of the enrollee and are subject to applicable reasonable and customary charge limitations.

IV. Limitations and Exclusions

Covered expenses will not include, and benefits are not payable for:

A. deductibles and copayments applied to covered expenses under any option available under another Appendix of this Program or out-of-pocket expenses incurred as sanctions because of failure to satisfy the Program provisions under such appendices;

B. services in the home in connection with routine nursing care of newborn children;

C. services not prescribed by a physician;

D. education or training (including such services when directed toward learning, behavioral or developmental deficiencies);

E. amounts covered by public programs providing benefits (such as those under laws pertaining to Worker's Compensation, non-occupational disability, old age assistance, veteran’s assistance, and any Federal or

state health insurance act providing nursing benefits);

F. amounts reimbursed by Medicare;

G. amounts in excess of the reasonable and customary charge or which are not considered to be necessary as determined by the carrier;

H. services available without cost: Coverage does not include services for which a charge would not have been made if no coverage existed; services for which the enrollee is not legally obligated to pay; or services which the enrollee received or, upon application, could receive without cost under the laws or regulations of the United States of America, Dominion of Canada, any other country, or any state or political subdivision thereof;

I. charges which duplicate benefits paid under another Appendix of the Program;

J. services provided by family members or relatives: Coverage does not include services provided to the enrollee by members of the enrollee's household or immediate relatives of the enrollee. For purposes of this provision, "immediate relative" refers to the enrollee's spouse, natural or adoptive parents, children or siblings, step-parents, -children or -siblings, father-, mother-, son-, daughter-, brother-, or sister-in-law, and grandparents or grandchildren of the enrollee or the enrollee's spouse;

K. services provided by a halfway house, group home, adult foster care facility, assisted living facility, rest home, adult day/night care, residential care, and the like; (for example, charges including but not limited to room, board and nursing care provided by such non-covered facilities);

L. non-medical supplies including, but not limited to, personal hygiene products, over-the-counter medications and personal items (including disablebriefs and diapers);

M. private duty nursing services for enrollees admitted to hospitals, skilled nursing facilities or nursing homes;

N. physical, functional occupational and speech therapy services;

O. charges for admissions, services, supplies and the like which are related to treatment of mental health and/or substance abuse disorders, whether or not such admissions, services, supplies and the like are covered under Appendices A and/or B of the Program. However, unskilled and/or custodial care provided by nurse professionals and meeting all other terms and conditions of this Appendix may still be covered; and

P. charges for services rendered prior to the effective date of, or after termination of coverage under this Appendix. However if a patient's covered and continuous admission to a hospital, skilled nursing facility or nursing home commences prior to termination of the coverage, benefits may be paid for that patient's admission until the earliest of discharge from the facility, exhaustion of the calendar year maximum and the end of the calendar year in which coverage is terminated.

Q. charges for room or facility reservations or the completion of any claim forms or record processing.